STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELLENIC SENIOR LIVING OF MISHAWAKA	1540 SOUTH LOGAN STREET, MISHAWAKA, , 46544

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00382161, IN00380822, IN00380787, IN00378381, and IN00377600. Complaint IN00382161 - Substantiated. State Residential Findings related to the allegations are cited at R0240. Complaint IN00380822 - Substantiated. State Residential Findings related to the allegations are cited at R0027 and R0090. Complaint IN00380787 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00378381 - Substantiated. State Residential Findings related to the allegations are cited at R0144 & R0240. Complaint IN00377600 - Unsubstantiated due to lack of	R 0000		

	evidence. Survey date: June 6, 7, 8, 9, 10, and 13, 2022 Facility number: 014224 Residential Census: 134 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 8/8/22.			
R 0027	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(b) (b) Residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Based on interview and record review, the facility failed to ensure resident rights to access services inside the facility were honored related to a call light taken away for 1 of 6 residents reviewed for resident rights. (Resident B) Finding includes: On 6/07/22 at 12:30 P.M.,	R 0027	ID R-0027 410 IAC 16.2-5-1.2 (b) Resident Rights Deficiency: Residents have the right to dignified existence, self-determination, and communication with and access with and access to persons and services inside and outside the facility. Residents have the right to exercise their rights as a resident of the facility and as a citizen or resident of the United States. Interventions . All staff in-service	08/22/2022

	Resident B's Move In Record was provided by Administrator A and reviewed at that time. The record indicated the Resident B was admitted to the facility on 7/30/21 with diagnoses that included, but were not limited to: Parkinson's Disease and overactive bladder. On 6/7/22 at 12:30 P.M., Incident Number: 40, dated 5/10/22 was provided by Administrator A, and reviewed at that time. The Incident report indicated on 5/10/22 at 5:01 P.M., "Was alerted 3rd party that the nurse [Registered Nurse name (RN 2)], had informed a private caregiver that she had put resident to bed and did not give him the call button as he continuously pushes it..." On 6/8/22 at 9:30 A.M., Resident B's Lease Agreement, dated 7/29/21, was provided by Administrator A and reviewed at that time. The Lease Agreement indicated, "...B. RESIDENT ACCOMMODATIONS...2. *Emergency Call System.* An electronic push button or pull cord device will be available to your Unit bathroom and a secondary emergency call device will be in your bedroom or can be worn by you that will enable you to summons assistance in the event of an emergency..." On 6/10/22 at 10:05 A.M., an		regarding Resident Rights by 8/22/2022 (See attached in-service documentation) . To ensure no allegations have been made and not reported 30 residents will be interviewed utilizing the ISDH questioner monthly for three months. Thereafter, 15 residents will be interviewed quarterly for an additional six months. Outcome . The Executive Director and Director of Nursing will monitor and review all concerns to ensure the deficit practice will not occur and will determine in Quality Improvement meetings.	

interview with Administrator A indicated RN 2 should have ensured Resident B had his call light when she put the resident to bed and the call light should never have been taken away.

Review of the facility's Resident Rights policy, with a revision date of 1/2021, was provided by the Administrator A as current. The policy indicated, "...(b) Residents have the right to a dignified existence, self-determination..."

This state residential finding relates to Complaint IN00380822.

Based on interview and record review, the facility failed to ensure resident rights to access services inside the facility were honored related to a call light taken away for 1 of 6 residents reviewed for resident rights. (Resident B)

Finding includes:

On 6/07/22 at 12:30 P.M., Resident B's Move In Record was provided by Administrator A and reviewed at that time. The record indicated the Resident B was admitted to the facility on 7/30/21 with diagnoses that included, but were not limited to: Parkinson's Disease and overactive bladder.

On 6/7/22 at 12:30 P.M., Incident Number: 40, dated

	5/10/22 was provided by Administrator A, and reviewed at that time. The Incident report indicated on 5/10/22 at 5:01 P.M., "Was alerted 3rd party that the nurse [Registered Nurse name (RN 2)], had informed a private caregiver that she had put resident to bed and did not give him the call button as he continuously pushes it..." On 6/8/22 at 9:30 A.M., Resident B's Lease Agreement, dated 7/29/21, was provided by Administrator A and reviewed at that time. The Lease Agreement indicated, "...B. RESIDENT ACCOMMODATIONS...2. *Emergency Call System.* An electronic push button or pull cord device will be available to your Unit bathroom and a secondary emergency call device will be in your bedroom or can be worn by you that will enable you to summons assistance in the event of an emergency..." On 6/10/22 at 10:05 A.M., an interview with Administrator A indicated RN 2 should have ensured Resident B had his call light when she put the resident to bed and the call light should never have been taken away. Review of the facility's Resident Rights policy, with a revision date of 1/2021, was provided by the Administrator A as current. The policy indicated, "...(b)			

	Residents have the right to a dignified existence, self-determination..." This state residential finding relates to Complaint IN00380822.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.	R 0090	ID: R-0090 Administration and Management -deficiency IAC 16.2-5-1.3(g) (1-6): The administrator is responsible for the overall management of the facility. Interventions: . Nursing to be in serviced on the Unusual Occurrence policy and protocol for reporting abuse under the Unusual Occurrence policy that the community is to execute.	08/22/2022

	(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to ensure an unusual occurrence, and an allegation of abuse was reported to the State Agency		. The administrator will be in-serviced on 8/22/2022 On the importance of reporting to ISDH of any allegation of an incident by the Regional Director. . To ensure no allegations have been made and not reported 30 residents will be interviewed utilizing the ISDH questioner monthly for three months. Thereafter, 15 residents will be interviewed quarterly for an additional six months. Outcome: . Any areas of concerns will be addressed and reported immediately. . Audits will be reviewed monthly at the Quality Improvement meetings, to ensure compliance, (See Abuse Questionnaire Form)	

within 24 hours of becoming aware of the unusual occurrence and allegation of abuse, for 1 of 3 residents reviewed for accidents, (Resident B).

Finding includes:

On 6/7/22 at 12:30 P.M., Resident B's Move In Record was provided by Administrator A and reviewed at that time. The record indicated the Resident B was admitted to the facility on 7/30/21 with diagnoses that included,but were not limited to: Parkinson's Disease and overactive bladder.

On 6/10/22 at 2:00 P.M., Relocation Meeting notes, dated 6/03/22 were provided by Administrator A and reviewed at that time. The notes indicated Administrator A and the Director of Nursing met with Resident B's Power of Attorney (POA) on 6/3/22 when the POA stated that she had pictures of the resident at the hospital with bruises on his arms and face. The POA stated that the resident said that someone drug him across the room.

On 6/13/22 at 9:00 A.M., local Emergency Medical Service Incident #2022-0004354 was provided by Administrator A and reviewed at that time. The assessment time was documented as 6/03/22 at 2:01

	A.M., and indicated, "Pt [patient] was found on the floor of bathroom. Staff present does not know how he fell or how long he has been there...Pt is moaning and groaning when his R [right] hip is touched...Pt has some minor skin tears on his knuckles, no active bleeding noted...Pt transported to [local hospital]..." On 6/13/22 at 11:00 A.M., an interview with Administrator A indicated she did not report an allegation of abuse because on 6/03/22 in her meeting with the resident's POA, they talked about the abrasions to Resident B's knuckles and forehead, and that he had fallen face first and maybe the motion of the fall could have caused the injuries. Administrator A indicated the POA said that made sense, so she did not consider it abuse or think to report it. Administrator A indicated they initiated a fall investigation, but did not report the fall in a timely fashion and should have reported the fall and the allegation of abuse per the facility policy. Review of the facility's policy titled, "Unusual Occurrences," revised 1/21, and identified by Administrator A as the current Abuse Policy, was provided by Administrator A on 6/13/22 at 9:30 A.M., and reviewed at that time. The policy indicated, "...community will ensure that all			

unusual occurrences that directly threaten the welfare, safety or health of a resident will be reported to the ISDH and other appropriate authorities within twenty-four hours of become [sic] aware of the occurrence...a. physical abuse is a willful act against a resident...Examples include but are not limited to...shoving, pulling...."

This state residential finding relates to Complaint IN00380822.

Based on interview and record review, the facility failed to ensure an unusual occurrence, and an allegation of abuse was reported to the State Agency within 24 hours of becoming aware of the unusual occurrence and allegation of abuse, for 1 of 3 residents reviewed for accidents, (Resident B).

Finding includes:

On 6/7/22 at 12:30 P.M., Resident B's Move In Record was provided by Administrator A and reviewed at that time. The record indicated the Resident B was admitted to the facility on 7/30/21 with diagnoses that included,but were not limited to: Parkinson's Disease and overactive bladder.

On 6/10/22 at 2:00 P.M., Relocation Meeting notes, dated

	6/03/22 were provided by Administrator A and reviewed at that time. The notes indicated Administrator A and the Director of Nursing met with Resident B's Power of Attorney (POA) on 6/3/22 when the POA stated that she had pictures of the resident at the hospital with bruises on his arms and face. The POA stated that the resident said that someone drug him across the room. On 6/13/22 at 9:00 A.M., local Emergency Medical Service Incident #2022-0004354 was provided by Administrator A and reviewed at that time. The assessment time was documented as 6/03/22 at 2:01 A.M., and indicated, "Pt [patient] was found on the floor of bathroom. Staff present does not know how he fell or how long he has been there...Pt is moaning and groaning when his R [right] hip is touched...Pt has some minor skin tears on his knuckles, no active bleeding noted...Pt transported to [local hospital]..." On 6/13/22 at 11:00 A.M., an interview with Administrator A indicated she did not report an allegation of abuse because on 6/03/22 in her meeting with the resident's POA, they talked about the abrasions to Resident B's knuckles and forehead, and that he had fallen face first and maybe the motion of the fall			

	could have caused the injuries. Administrator A indicated the POA said that made sense, so she did not consider it abuse or think to report it. Administrator A indicated they initiated a fall investigation, but did not report the fall in a timely fashion and should have reported the fall and the allegation of abuse per the facility policy. Review of the facility's policy titled, "Unusual Occurrences," revised 1/21, and identified by Administrator A as the current Abuse Policy, was provided by Administrator A on 6/13/22 at 9:30 A.M., and reviewed at that time. The policy indicated, "...community will ensure that all unusual occurrences that directly threaten the welfare, safety or health of a resident will be reported to the ISDH and other appropriate authorities within twenty-four hours of become [sic] aware of the occurrence...a. physical abuse is a willful act against a resident...Examples include but are not limited to...shoving, pulling...." This state residential finding relates to Complaint IN00380822.			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a)	R 0144	ID: R-0144	08/22/2022

	(a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, interview, and record review, the facility failed to ensure a safe, clean environment for 1 of 6 resident rooms reviewed for environment, (Resident D). Finding includes: During an observation on 6/8/22 at 12:00 P.M., Resident D's apartment was observed to have dust on the furniture surfaces throughout. There was a sticky area the tile floor in front of the refrigerator approximately 8 inches in diameter. The shower seat in the resident's shower had a dried brown smeared substance approximately 2 inches by 6, and a bar of soap was noted on the floor of the shower.		Sanitation and Safety Standards -Deficiency-410 IAC 16.2-5-1.5 (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Intervention: . Assigned Environmental Service team members will utilize cleaning schedules that will require signatures of completion. In-service will be proved to Environment staff. . The facility has hired the efficient number of staff accordingly as of 8/22/2022, to ensure that all environmental responsibilities are completed. . Administrator will monitor assigned task daily for five days a week for three months to ensure all residents apartments have been	

	An interview with Resident D at the time of the observation indicated the apartment did not get cleaned regularly. The apartments were supposed to be cleaned every week, but housekeeping was cleaning every other week because they were short staffed. Resident D indicated the housekeeper did a good job of cleaning when she was able to come, but that the housekeeper needed help. The resident indicated she and her daughter had cleaned her apartment since the facility was not able to keep up. On 6/6/22 at 2:36 P.M., an interview with the Housekeeper indicated she was the only housekeeper for 128 rooms and was not able to clean all of the rooms as often as she was supposed to. Every resident room was supposed to be cleaned every week, which included, but was not limited to, cleaning the bathroom and shower, vacuuming the carpeting, mopping uncarpeted floors, wiping surfaces and emptying trash. The housekeeper indicated her current routine was to clean even numbered rooms one week and odd numbered rooms the next week. Interview with Administrator A on 6/7/2022 at 12:48 P.M., indicated resident rooms were supposed to be cleaned every		cleaned, as resident allows. Outcome: . 100 % of all resident's apartment will be assigned weekly to a schedule that the assigned team member will be responsible for to ensure compliance. . Residents will receive Environmental Services based on their Service Plan.	

	week, but due to staffing shortages, the rooms were not being cleaned every week. Administrator A indicated Resident D did not have a Service Plan that specified services the resident required, but that the room should be cleaned by the facility housekeeping staff every week. A policy regarding environmental cleaning schedule was requested, but none was provided by the facility by the time the survey was exited. This Residential Tag is related to Complaint IN00378381 Based on observation, interview, and record review, the facility failed to ensure a safe, clean environment for 1 of 6 resident rooms reviewed for environment, (Resident D). Finding includes:			

	During an observation on 6/8/22 at 12:00 P.M., Resident D's apartment was observed to have dust on the furniture surfaces throughout. There was a sticky area the tile floor in front of the refrigerator approximately 8 inches in diameter. The shower seat in the resident's shower had a dried brown smeared substance approximately 2 inches by 6, and a bar of soap was noted on the floor of the shower. An interview with Resident D at the time of the observation indicated the apartment did not get cleaned regularly. The apartments were supposed to be cleaned every week, but housekeeping was cleaning every other week because they were short staffed. Resident D indicated the housekeeper did a good job of cleaning when she was able to come, but that the housekeeper needed help. The resident indicated she and her daughter had cleaned her apartment since the facility was not able to keep up. On 6/6/22 at 2:36 P.M., an interview with the Housekeeper indicated she was the only housekeeper for 128 rooms and was not able to clean all of the rooms as often as she was supposed to. Every resident room was supposed to be cleaned every week, which included, but was not limited to,			

	cleaning the bathroom and shower, vacuuming the carpeting, mopping uncarpeted floors, wiping surfaces and emptying trash. The housekeeper indicated her current routine was to clean even numbered rooms one week and odd numbered rooms the next week. Interview with Administrator A on 6/7/2022 at 12:48 P.M., indicated resident rooms were supposed to be cleaned every week, but due to staffing shortages, the rooms were not being cleaned every week. Administrator A indicated Resident D did not have a Service Plan that specified services the resident required, but that the room should be cleaned by the facility housekeeping staff every week. A policy regarding environmental cleaning schedule was requested, but none was provided by the facility by the time the survey was exited. This Residential Tag is related to Complaint IN00378381			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual	R 0240	ID: R-240 Health Services – deficiency 410 IAC 16.2-5-4(d): Personal care and assistance with	08/22/2022

	needs and preferences. 2. On 6/7/22 at 12:30 P.M., Resident D's Move In Record was provided by Administrator A and reviewed at that time. The record indicated Resident D was admitted to the facility on 5/1/21 with diagnoses that included, but were not limited to: history of falling. On 6/7/22 at 10:40 A.M., the shower list was provided by Administrator A, and reviewed at that time. The shower list indicated Resident D was to receive shower assistance on Mondays and Thursdays during second shift. On 6/7/22 at 12:48 P.M., an interview with Administrator A indicated Resident D should have assistance with showers on Monday and Thursday afternoons. Administrator A indicated there was no documentation that showers were being given and Resident D should have assistance with showers 2 times every week. The facility did not have a Service Plan for the resident so they determined the resident should have 2 showers weekly according to the shower list. On 6/8/22 at 12:00 P.M., in an interview with Resident D, she indicated she was to get assistance with showers 2 times weekly. She rarely received help		activities of daily living, shall be provided based upon individual needs and preferences. Interventions: . Level of care assessments along with service planes will be completed on admission, 30 days after move in, quarterly and with change in condition based on individual resident needs. . 1/3 of resident Level of care assessments and service plans will be completed each month by the Director of Nursing and will be individualized based on resident needs and resident involvement with care services needed.	

	with showers 2 times weekly and sometimes does not get any showers in a week. The resident indicated she needed help with washing her back and was not steady in the shower without help. On 6/10/22 at 1:30 P.M., an interview with Qualified Medication Aide (QMA) 2, indicated she assisted Resident D with showers, but Resident D did not always get 2 showers weekly. QMA 2 also indicated, "we don't always get her laundry done. Certified Nursing Assistants (CNA) are supposed to do it, but we don't always get it done." Review of the facility's Resident Rights policy, with a revision date of 1/2021, was provided by the Administrator A as current. The policy indicated, "...(b) Residents have the right to a dignified existence, self-determination..." This state residential finding relates to Complaints IN00378381 and IN00382161. Based on interview and record review, the facility failed to provide personal care and assistance with activities of daily living based upon individual needs and preferences related to not completing a daily wellness check as per service agreement and bathing and		. All tasks including but limited to bathing, laundry, daily wellness checks will be implemented per resident choice on resident service plan and documented on assigned days in the PointClick Care system. . Director of Nursing will monitor assigned task in PointClick Care once daily five times a week for three months, then two times a week for three months to ensure all individual resident task have been completed. Outcome: . 100% of residents will have accurate Level of Care assessments and Service plans within 90 days of implementation. . Residents will receive care needs based on individual needs .	

	laundry services for 2 of 6 residents reviewed for resident rights. (Residents H & D) Findings include: 1. On 6/7/22 at 12:30 P.M., Resident H's Move In Record was provided by Administrator A and reviewed at that time. The record indicated the Resident H was admitted to the facility on 7/30/21. Diagnoses included, but were not limited to, bipolar disorder, current episode depressed, moderate, Alcohol use, unspecified with unspecified alcohol-induced disorder, and essential primary hypertension. On 6/7/22 at 7:44 P.M., the following was provided by the POA via Email: The POA went to visit Resident H in the afternoon on Saturday April 2nd and he was doing great, said he had a fall earlier in the week and it surprised him, but that he was ok. On Saturday, Resident H had asked the POA to call him after the closing of their family home on Monday. The POA indicated he sounded as if he just woke up and didn't seem to want to talk. On 4/5/22, a dialysis nurse called the POA at 6:45 A.M. to let her know the resident had not shown up for dialysis. The dialysis nurse had told the POA the resident had called her to let her know he had fallen and the dialysis nurse		All resident tasks will be documented in PointClick Care with 100% compliance.	

felt something was wrong. The POA indicated she went to the facility, and was let into the resident's room by a QMA who was on duty. She found the resident " ...on his bed with his arms and legs moving in large random, jerking motions he was rocking his head from side to side. Resident H could speak, but it was difficult to understand him because his tongue was swollen. Resident H told the POA that he had fallen and his head, back, abdomen and foot hurt. He asked for water. Resident H was unable to stand or support his weight. A nurse came to the room after approximately 15 to 20 minutes and asked the resident why he did not want to go to dialysis. The POA indicated Resident H could not clearly speak at that time and that he was moving his head from side to side along with random jerking motions of his arms and legs. The POA indicated the nurse noted diarrhea on Resident H's chair, floor, and bed. Resident H was sent to the hospital at the request of POA.

On 6/13/22 at 9:00 A.M., a local Emergency Medical Service Incident Report was provided and reviewed at that time. The assessment time was documented as 4/5/22 at 8:24 A.M. The Report indicated "...dispatched priority 5 for falls. Upon arrival, patient is found

laying in bed in his apartment at a nursing facility. His sister is present. Chief Complaint is thirst. Patient states that on Saturday he started having excessive thirst and loss of appetite. He also had some dizzy spells but never passed out. today, his sister is worried because when she saw him on Saturday he seemed fine and now he is too weak to bear weight on his own and has some twitching all over his body. He was not able to make it to dialysis this morning due to his weakness. Patient is pale and seems weak. He is alert and oriented but does need help transferring to the cot. He states that he does have a little pain from his fall and denies neck pain or restricted movement. Patient's initial BP [blood pressure] is 93/44...Patient denies any difficulty breathing. He states he is still having the excessive thirst and his tongue is white...."

A Emergency Room (ER) Provider Note, with a creation time of 4/5/22 at 12:05 P.M., indicated the resident came into the Emergency Department after a fall and was a dialysis patient.

A Nurse's Note, dated 4/5/2022 at 9:27 A.M., indicated the writer had been called to the resident's apartment. His sister was present, he was noted to be

restless, he was asked why he did not go to dialysis and he told the writer he fell the day before from his steel chair and hit the back of his head and had not felt right since. He indicated he did not report the fall to anyone. The note indicated his sister wanted him to go to the ER.

A Nurse's Note, dated 4/5/2022 at 10:33 A.M., indicated a call was placed to a local hospital with regard to update in status. Resident was admitted with diagnosis of colitis.

A Service Agreement, dated 1/28/22, indicated Resident H was to receive daily wellness checks.

On 6/13/22 at 11:00 A.M., an interview with Administrator A indicated the resident had not been checked on daily.

On 6/8/22 at 9:30 A.M., Resident H's Lease Agreement, dated 7/29/21, was provided by Administrator A and reviewed at that time. The Lease Agreement indicated, "...H. Daily checks- The owner shall implement a system to check on residents welfare, daily...."

2. On 6/7/22 at 12:30 P.M., Resident D's Move In Record was provided by Administrator A and reviewed at that time. The record indicated Resident D was admitted to the facility on 5/1/21 with diagnoses that included,

but were not limited to: history of falling.

On 6/7/22 at 10:40 A.M., the shower list was provided by Administrator A, and reviewed at that time. The shower list indicated Resident D was to receive shower assistance on Mondays and Thursdays during second shift.

On 6/7/22 at 12:48 P.M., an interview with Administrator A indicated Resident D should have assistance with showers on Monday and Thursday afternoons. Administrator A indicated there was no documentation that showers were being given and Resident D should have assistance with showers 2 times every week. The facility did not have a Service Plan for the resident so they determined the resident should have 2 showers weekly according to the shower list.

On 6/8/22 at 12:00 P.M., in an interview with Resident D, she indicated she was to get assistance with showers 2 times weekly. She rarely received help with showers 2 times weekly and sometimes does not get any showers in a week. The resident indicated she needed help with washing her back and was not steady in the shower without help.

On 6/10/22 at 1:30 P.M., an

interview with Qualified Medication Aide (QMA) 2, indicated she assisted Resident D with showers, but Resident D did not always get 2 showers weekly. QMA 2 also indicated, "we don't always get her laundry done. Certified Nursing Assistants (CNA) are supposed to do it, but we don't always get it done."

Review of the facility's Resident Rights policy, with a revision date of 1/2021, was provided by the Administrator A as current. The policy indicated, "...(b) Residents have the right to a dignified existence, self-determination..."

This state residential finding relates to Complaints IN00378381 and IN00382161.

Based on interview and record review, the facility failed to provide personal care and assistance with activities of daily living based upon individual needs and preferences related to not completing a daily wellness check as per service agreement and bathing and laundry services for 2 of 6 residents reviewed for resident rights. (Residents H & D)

Findings include:

1. On 6/7/22 at 12:30 P.M., Resident H's Move In Record was provided by Administrator A and reviewed at that time. The

record indicated the Resident H was admitted to the facility on 7/30/21. Diagnoses included, but were not limited to, bipolar disorder, current episode depressed, moderate, Alcohol use, unspecified with unspecified alcohol-induced disorder, and essential primary hypertension.

On 6/7/22 at 7:44 P.M., the following was provided by the POA via Email: The POA went to visit Resident H in the afternoon on Saturday April 2nd and he was doing great, said he had a fall earlier in the week and it surprised him, but that he was ok. On Saturday, Resident H had asked the POA to call him after the closing of their family home on Monday. The POA indicated he sounded as if he just woke up and didn't seem to want to talk. On 4/5/22, a dialysis nurse called the POA at 6:45 A.M. to let her know the resident had not shown up for dialysis. The dialysis nurse had told the POA the resident had called her to let her know he had fallen and the dialysis nurse felt something was wrong. The POA indicated she went to the facility, and was let into the resident's room by a QMA who was on duty. She found the resident " ...on his bed with his arms and legs moving in large random, jerking motions he was rocking his head from side to side. Resident H could speak,

but it was difficult to understand him because his tongue was swollen. Resident H told the POA that he had fallen and his head, back, abdomen and foot hurt. He asked for water. Resident H was unable to stand or support his weight. A nurse came to the room after approximately 15 to 20 minutes and asked the resident why he did not want to go to dialysis. The POA indicated Resident H could not clearly speak at that time and that he was moving his head from side to side along with random jerking motions of his arms and legs. The POA indicated the nurse noted diarrhea on Resident H's chair, floor, and bed. Resident H was sent to the hospital at the request of POA.

On 6/13/22 at 9:00 A.M., a local Emergency Medical Service Incident Report was provided and reviewed at that time. The assessment time was documented as 4/5/22 at 8:24 A.M. The Report indicated "...dispatched priority 5 for falls. Upon arrival, patient is found laying in bed in his apartment at a nursing facility. His sister is present. Chief Complaint is thirst. Patient states that on Saturday he started having excessive thirst and loss of appetite. He also had some dizzy spells but never passed out. today, his sister is worried because when she saw him on

Saturday he seemed fine and now he is too weak to bear weight on his own and has some twitching all over his body. He was not able to make it to dialysis this morning due to his weakness. Patient is pale and seems weak. He is alert and oriented but does need help transferring to the cot. He states that he does have a little pain from his fall and denies neck pain or restricted movement. Patient's initial BP [blood pressure] is 93/44...Patient denies any difficulty breathing. He states he is still having the excessive thirst and his tongue is white...."

A Emergency Room (ER) Provider Note, with a creation time of 4/5/22 at 12:05 P.M., indicated the resident came into the Emergency Department after a fall and was a dialysis patient.

A Nurse's Note, dated 4/5/2022 at 9:27 A.M., indicated the writer had been called to the resident's apartment. His sister was present, he was noted to be restless, he was asked why he did not go to dialysis and he told the writer he fell the day before from his steel chair and hit the back of his head and had not felt right since. He indicated he did not report the fall to anyone. The note indicated his sister wanted him to go to the ER.

A Nurse's Note, dated 4/5/2022 at 10:33 A.M., indicated a call was placed to a local hospital with regard to update in status. Resident was admitted with diagnosis of colitis.

A Service Agreement, dated 1/28/22, indicated Resident H was to receive daily wellness checks.

On 6/13/22 at 11:00 A.M., an interview with Administrator A indicated the resident had not been checked on daily.

On 6/8/22 at 9:30 A.M., Resident H's Lease Agreement, dated 7/29/21, was provided by Administrator A and reviewed at that time. The Lease Agreement indicated, "...H. Daily checks- The owner shall implement a system to check on residents welfare, daily...."

2. On 6/7/22 at 12:30 P.M., Resident D's Move In Record was provided by Administrator A and reviewed at that time. The record indicated Resident D was admitted to the facility on 5/1/21 with diagnoses that included, but were not limited to: history of falling.

On 6/7/22 at 10:40 A.M., the shower list was provided by Administrator A, and reviewed at that time. The shower list indicated Resident D was to receive shower assistance on Mondays and Thursdays during

second shift.

On 6/7/22 at 12:48 P.M., an interview with Administrator A indicated Resident D should have assistance with showers on Monday and Thursday afternoons. Administrator A indicated there was no documentation that showers were being given and Resident D should have assistance with showers 2 times every week. The facility did not have a Service Plan for the resident so they determined the resident should have 2 showers weekly according to the shower list.

On 6/8/22 at 12:00 P.M., in an interview with Resident D, she indicated she was to get assistance with showers 2 times weekly. She rarely received help with showers 2 times weekly and sometimes does not get any showers in a week. The resident indicated she needed help with washing her back and was not steady in the shower without help.

On 6/10/22 at 1:30 P.M., an interview with Qualified Medication Aide (QMA) 2, indicated she assisted Resident D with showers, but Resident D did not always get 2 showers weekly. QMA 2 also indicated, "we don't always get her laundry done. Certified Nursing Assistants (CNA) are supposed to do it, but we don't always get

	it done." Review of the facility's Resident Rights policy, with a revision date of 1/2021, was provided by the Administrator A as current. The policy indicated, "...(b) Residents have the right to a dignified existence, self-determination..." This state residential finding relates to Complaints IN00378381 and IN00382161. Based on interview and record review, the facility failed to provide personal care and assistance with activities of daily living based upon individual needs and preferences related to not completing a daily wellness check as per service agreement and bathing and laundry services for 2 of 6 residents reviewed for resident rights. (Residents H & D) Findings include:			

1. On 6/7/22 at 12:30 P.M., Resident H's Move In Record was provided by Administrator A and reviewed at that time. The record indicated the Resident H was admitted to the facility on 7/30/21. Diagnoses included, but were not limited to, bipolar disorder, current episode depressed, moderate, Alcohol use, unspecified with unspecified alcohol-induced disorder, and essential primary hypertension.

On 6/7/22 at 7:44 P.M., the following was provided by the POA via Email: The POA went to visit Resident H in the afternoon on Saturday April 2nd and he was doing great, said he had a fall earlier in the week and it surprised him, but that he was ok. On Saturday, Resident H had asked the POA to call him after the closing of their family home on Monday. The POA indicated he sounded as if he just woke up and didn't seem to want to talk. On 4/5/22, a dialysis nurse called the POA at 6:45 A.M. to let her know the resident had not shown up for dialysis. The dialysis nurse had told the POA the resident had called her to let her know he had fallen and the dialysis nurse felt something was wrong. The POA indicated she went to the facility, and was let into the resident's room by a QMA who was on duty. She found the resident " ...on his bed with his

arms and legs moving in large random, jerking motions he was rocking his head from side to side. Resident H could speak, but it was difficult to understand him because his tongue was swollen. Resident H told the POA that he had fallen and his head, back, abdomen and foot hurt. He asked for water. Resident H was unable to stand or support his weight. A nurse came to the room after approximately 15 to 20 minutes and asked the resident why he did not want to go to dialysis. The POA indicated Resident H could not clearly speak at that time and that he was moving his head from side to side along with random jerking motions of his arms and legs. The POA indicated the nurse noted diarrhea on Resident H's chair, floor, and bed. Resident H was sent to the hospital at the request of POA.

On 6/13/22 at 9:00 A.M., a local Emergency Medical Service Incident Report was provided and reviewed at that time. The assessment time was documented as 4/5/22 at 8:24 A.M. The Report indicated "...dispatched priority 5 for falls. Upon arrival, patient is found laying in bed in his apartment at a nursing facility. His sister is present. Chief Complaint is thirst. Patient states that on Saturday he started having excessive thirst and loss of

appetite. He also had some dizzy spells but never passed out. today, his sister is worried because when she saw him on Saturday he seemed fine and now he is too weak to bear weight on his own and has some twitching all over his body. He was not able to make it to dialysis this morning due to his weakness. Patient is pale and seems weak. He is alert and oriented but does need help transferring to the cot. He states that he does have a little pain from his fall and denies neck pain or restricted movement. Patient's initial BP [blood pressure] is 93/44...Patient denies any difficulty breathing. He states he is still having the excessive thirst and his tongue is white...."

A Emergency Room (ER) Provider Note, with a creation time of 4/5/22 at 12:05 P.M., indicated the resident came into the Emergency Department after a fall and was a dialysis patient.

A Nurse's Note, dated 4/5/2022 at 9:27 A.M., indicated the writer had been called to the resident's apartment. His sister was present, he was noted to be restless, he was asked why he did not go to dialysis and he told the writer he fell the day before from his steel chair and hit the back of his head and had not felt right since. He indicated he

did not report the fall to anyone. The note indicated his sister wanted him to go to the ER.

A Nurse's Note, dated 4/5/2022 at 10:33 A.M., indicated a call was placed to a local hospital with regard to update in status. Resident was admitted with diagnosis of colitis.

A Service Agreement, dated 1/28/22, indicated Resident H was to receive daily wellness checks.

On 6/13/22 at 11:00 A.M., an interview with Administrator A indicated the resident had not been checked on daily.

On 6/8/22 at 9:30 A.M., Resident H's Lease Agreement, dated 7/29/21, was provided by Administrator A and reviewed at that time. The Lease Agreement indicated, "...H. Daily checks- The owner shall implement a system to check on residents welfare, daily...."

2. On 6/7/22 at 12:30 P.M., Resident D's Move In Record was provided by Administrator A and reviewed at that time. The record indicated Resident D was admitted to the facility on 5/1/21 with diagnoses that included, but were not limited to: history of falling.

On 6/7/22 at 10:40 A.M., the shower list was provided by Administrator A, and reviewed

at that time. The shower list indicated Resident D was to receive shower assistance on Mondays and Thursdays during second shift.

On 6/7/22 at 12:48 P.M., an interview with Administrator A indicated Resident D should have assistance with showers on Monday and Thursday afternoons. Administrator A indicated there was no documentation that showers were being given and Resident D should have assistance with showers 2 times every week. The facility did not have a Service Plan for the resident so they determined the resident should have 2 showers weekly according to the shower list.

On 6/8/22 at 12:00 P.M., in an interview with Resident D, she indicated she was to get assistance with showers 2 times weekly. She rarely received help with showers 2 times weekly and sometimes does not get any showers in a week. The resident indicated she needed help with washing her back and was not steady in the shower without help.

On 6/10/22 at 1:30 P.M., an interview with Qualified Medication Aide (QMA) 2, indicated she assisted Resident D with showers, but Resident D did not always get 2 showers weekly. QMA 2 also indicated,

"we don't always get her laundry done. Certified Nursing Assistants (CNA) are supposed to do it, but we don't always get it done."

Review of the facility's Resident Rights policy, with a revision date of 1/2021, was provided by the Administrator A as current. The policy indicated, "...(b) Residents have the right to a dignified existence, self-determination..."

This state residential finding relates to Complaints IN00378381 and IN00382161.

Based on interview and record review, the facility failed to provide personal care and assistance with activities of daily living based upon individual needs and preferences related to not completing a daily wellness check as per service agreement and bathing and laundry services for 2 of 6 residents reviewed for resident rights. (Residents H & D)

Findings include:

1. On 6/7/22 at 12:30 P.M., Resident H's Move In Record was provided by Administrator A and reviewed at that time. The record indicated the Resident H was admitted to the facility on 7/30/21. Diagnoses included, but were not limited to, bipolar disorder, current episode depressed, moderate, Alcohol

use, unspecified with unspecified alcohol-induced disorder, and essential primary hypertension.

On 6/7/22 at 7:44 P.M., the following was provided by the POA via Email: The POA went to visit Resident H in the afternoon on Saturday April 2nd and he was doing great, said he had a fall earlier in the week and it surprised him, but that he was ok. On Saturday, Resident H had asked the POA to call him after the closing of their family home on Monday. The POA indicated he sounded as if he just woke up and didn't seem to want to talk. On 4/5/22, a dialysis nurse called the POA at 6:45 A.M. to let her know the resident had not shown up for dialysis. The dialysis nurse had told the POA the resident had called her to let her know he had fallen and the dialysis nurse felt something was wrong. The POA indicated she went to the facility, and was let into the resident's room by a QMA who was on duty. She found the resident " ...on his bed with his arms and legs moving in large random, jerking motions he was rocking his head from side to side. Resident H could speak, but it was difficult to understand him because his tongue was swollen. Resident H told the POA that he had fallen and his head, back, abdomen and foot hurt. He asked for water.

Resident H was unable to stand or support his weight. A nurse came to the room after approximately 15 to 20 minutes and asked the resident why he did not want to go to dialysis. The POA indicated Resident H could not clearly speak at that time and that he was moving his head from side to side along with random jerking motions of his arms and legs. The POA indicated the nurse noted diarrhea on Resident H's chair, floor, and bed. Resident H was sent to the hospital at the request of POA.

On 6/13/22 at 9:00 A.M., a local Emergency Medical Service Incident Report was provided and reviewed at that time. The assessment time was documented as 4/5/22 at 8:24 A.M. The Report indicated "...dispatched priority 5 for falls. Upon arrival, patient is found laying in bed in his apartment at a nursing facility. His sister is present. Chief Complaint is thirst. Patient states that on Saturday he started having excessive thirst and loss of appetite. He also had some dizzy spells but never passed out. today, his sister is worried because when she saw him on Saturday he seemed fine and now he is too weak to bear weight on his own and has some twitching all over his body. He was not able to make it to dialysis this morning due to his

	weakness. Patient is pale and seems weak. He is alert and oriented but does need help transferring to the cot. He states that he does have a little pain from his fall and denies neck pain or restricted movement. Patient's initial BP [blood pressure] is 93/44...Patient denies any difficulty breathing. He states he is still having the excessive thirst and his tongue is white...." A Emergency Room (ER) Provider Note, with a creation time of 4/5/22 at 12:05 P.M., indicated the resident came into the Emergency Department after a fall and was a dialysis patient. A Nurse's Note, dated 4/5/2022 at 9:27 A.M., indicated the writer had been called to the resident's apartment. His sister was present, he was noted to be restless, he was asked why he did not go to dialysis and he told the writer he fell the day before from his steel chair and hit the back of his head and had not felt right since. He indicated he did not report the fall to anyone. The note indicated his sister wanted him to go to the ER.			

	A Nurse's Note, dated 4/5/2022 at 10:33 A.M., indicated a call was placed to a local hospital with regard to update in status. Resident was admitted with diagnosis of colitis. A Service Agreement, dated 1/28/22, indicated Resident H was to receive daily wellness checks. On 6/13/22 at 11:00 A.M., an interview with Administrator A indicated the resident had not been checked on daily. On 6/8/22 at 9:30 A.M., Resident H's Lease Agreement, dated 7/29/21, was provided by Administrator A and reviewed at that time. The Lease Agreement indicated, "...H. Daily checks- The owner shall implement a system to check on residents welfare, daily...."			

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 PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE