STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TOWNE CENTRE ASSISTED LIVING LLC	7252 ARTHUR BLVD MERRILLVILLE, IN 46410

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00377550, IN00378152, IN00378896, IN00379284, IN00381495, IN00382665, and IN00384290. Complaint IN00377550 - Substantiated. State deficiencies related to the allegations are cited at R0036. Complaint IN00378152 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00378896 - Unsubstantiated due to lack of evidence. Complaint IN00379284 - Substantiated. State deficiencies related to the allegations are cited at R0349. Complaint IN00381495 - Substantiated. State deficiencies related to the allegations are cited at R0243. Complaint IN00382665 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00384290 - Substantiated. State deficiencies related to the allegations are cited at R0091 and R0349. Survey dates: July 25, 26, and 27, 2022. Facility number: 002392 Residential Census: 216	R 0000	"This plan of correction is submitted as required under State and Federal Law. The submission of the Plan of Correction does not constitute an admission on conclusions drawn therefrom- Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as the concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies."	

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

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	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/1/22.			
R 0002 Bldg. 00	410 IAC 16.2-5-0.5(b) Scope of Residential Care - Offense (b) A residential care facility may not provide comprehensive nursing care except to the extent allowed under this rule. Based on record review and interview, the facility failed to ensure care that involved comprehensive nursing care was not provided, related to wound care treatments for a large, complicated pressure ulcer for 1 of 2 residents reviewed for pressure ulcers which resulted in a deterioration of the pressure ulcer. (Resident D) Finding includes: The record for Resident D was reviewed on 7/26/22 at 10:28 a.m. Diagnoses included, but were not limited to, dementia and anorexia. The Service Plan, dated 4/5/22, indicated the resident was cognitively impaired for daily decision making and was dependent on staff for transfers. The resident was identified as receiving hospice services. The Pressure Ulcer Evaluation Report, dated 4/25/22, indicated the resident had a stage 2 pressure ulcer to the right coccyx that measured 6 centimeters (cm) x 4 cm x 0.2 cm and a stage 2 pressure ulcer to the left coccyx that measured 1 cm x 3 cm x 0.2 cm. Documentation indicated a new treatment had been ordered. A Physician's Order, dated 4/26/22, indicated the area to the coccyx and bilateral buttocks was to be	R 0002	The correction action accomplished for resident D-per family request resident changed hospices providers to better support care needs and offer increased services. Orders were revised on 4/27/22 to reflect the assurance of residential care scope and compliance. The facility identified other residents having the potential to be affected by the alleged deficient practice, an audit was completed of all medical records on 8/10/22 utilizing an audit tool. DON and or designee will review all treatment and wound orders to ensure the facility is practicing within the scope of our residential licensure. The corrective action will be the monitoring of orders utilizing a physician order audit tool 3 times per week for 30 week then weekly for 6 months. The date of systemic changes are 8/22/22	08/22/2022

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	cleansed, the area was to be patted dry, skin prep applied, Flagyl (an antibiotic) powder was to be applied to the wound bed, apply Dakin's (an antiseptic solution) soiled gauze and then cover with a foam dressing. The treatment was to be completed daily with hospice completing the treatment on Monday, Wednesday, and Friday and facility staff completing the treatment on Tuesday, Thursday, Saturday, and Sunday. The April 2022 Treatment Administration Record (TAR), indicated facility staff had signed out the treatment as being completed on 4/26, 4/28, and 4/30/22. The May 2022 TAR, indicated facility staff had signed out the treatment as being completed on 5/1, 5/3, 5/5, 5/7, 5/8, 5/10, 5/12, 5/14, 5/15, 5/17, 5/19, 5/21, and 5/22/22. The Pressure Ulcer Evaluation Report, dated 5/11/22, indicated the pressure area to the right coccyx was now a stage 3 and measured 5 cm x 3.5 cm x 2 cm with slight drainage. The next documented measurements were on 5/23/22, the site was identified as a stage 4 to the sacrum that measured 4.5 cm x 4 cm with 5 cm tunneling at 12 o'clock, 3 cm tunneling at 3 o'clock, and 2.5 cm at 9 o'clock. The area had moderate serosanguinous (yellowish drainage with small amounts of blood) drainage. New treatment orders were obtained at that time. Interview with the Director of Nursing on 7/27/22 at 8:45 a.m., indicated facility staff had completed the treatment in April and May 2022 and other arrangements should have been made. Interview with the Administrator on 7/27/22 at 3:00 p.m., indicated the treatment should not have			

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	been completed by facility staff due to it being a major skin treatment and not a minor one.			
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on observation, record review, and interview, the facility failed to ensure the Physician and/or the resident's Responsible Party was notified following a change in condition related to a hospital return and bruising for 2 of 13 sampled residents. (Residents B and E) Findings include: 1. The record for Resident B was reviewed on 7/27/22 at 9:04 a.m. Diagnoses included, but were not limited to, delusional disorder and depression. The Service Plan, dated 4/5/22, indicated the resident was oriented to person with moderate impairment. She required moderate assistance with ambulation and transfers and was at risk for falls. Nurses' Notes, dated 6/29/22 at 4:45 p.m., indicated the resident was observed on the floor with blood coming from the back of her head. Upon assessment, the resident had a laceration to the back of her head with active bleeding. 911 was called and the resident was transported to the	R 0036	The corrective actions for those residents found to be affected by deficient practice were on 7/27/2022 the attending physician and responsible party were notified. On 8/22/22 an audit of all residents charts were reviewed by DON and Unit Manager to ensure all attending physicians and responsible parties were notified. Any concerns discovered were corrected at that time. The measures put into place to ensure the deficient practice does not recur is :all nurses notes will be reviewed 5 days a week by Director of Nursing and or designee for 12 months to ensure compliance and monitoring utilizing an audit tool. The date of the systemic changes will be 8/22/22.	08/22/2022

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	hospital. At 4:56 p.m., the Nurse Practitioner (NP), the resident's Responsible Party and the Director of Nursing were notified of the laceration. At 8:10 p.m., the resident returned from the emergency room with 4 staples to the back of the head. Documentation indicated no new orders were given and staff would continue to monitor. There was no documentation indicating the resident's Physician or NP were notified of the resident's return to the facility. There was also no documentation indicating the resident's Responsible Party had been notified of her return to the facility. Interview with the Administrator on 7/27/22 at 3:00 p.m., indicated the NP and the resident's Responsible Party should have been notified of her return to the facility.2. On 7/26/22 at 11:20 a.m., Resident E was observed to have discoloration to her right eye orbital area and fading discoloration to her left forearm. Interview with the resident at that time, indicated she woke up one morning about a week ago and noticed the eye discoloration. She did not recall how it happened. The record for Resident E was reviewed on 7/25/22 at 1:00 p.m. Diagnoses included, but were not limited to, lung cancer and heart disease. A Nurse's Note, dated 7/18/22 at 6:00 p.m., indicated, the resident was sitting on the floor in front of her chair. She indicated she fell but she wasn't able to elaborate with any further details. No bruises were noted and a scratch was present on the left upper thigh. There was no documentation indicating the			

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	physician was notified of the fall. A message was left for the resident's daughter at 10:00 p.m. A Nurse's Note, dated 7/21/22 at 8:00 a.m., indicated, the "resident's caregiver reported discoloration to L [left] outer eyelid and orbital. Also has discoloration to L elbow. Denies pain or discomfort. Currently on Plavix 75 milligrams [mg] . Daily communication forwarded to Dr. [Physician's name], family notified." There was no further documentation of any follow up with the resident's Physician. Interview with the Director of Nursing on 7/26/22 at 2:15 p.m., indicated the Unit Manager was aware of the incident but she had not been notified. The current Fall Management Handbook was provided by the Administrator on 7/27/2022. The policy indicated the Physician was to be notified of any falls and orders implemented. This state residential finding relates to Complaint IN00377550.			
R 0059 Bldg. 00	410 IAC 16.2-5-1.2(cc) Residents' Rights - Noncompliance (cc) Residents have the right to choose with whom they associate. The facility shall provide reasonable visiting hours, which should include at least twelve (12) hours a day, and the hours shall be made available to each resident. Policies shall also provide for emergency visitation at other hours. The facility shall not restrict visits from the resident ' s legal representative or spiritual advisor, except at the request of the resident. Based on observation, record review, and	R 0059	The corrective actions	08/28/2022

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	interview, the facility failed to ensure visitation was allowed on 1 of 3 units after a resident tested positive for COVID-19. (The Memory Care Unit) Finding includes: On 7/26/22 at 9:25 a.m., a sign was posted on the Memory Care Unit (MCU) doors indicating visitation was suspended and only hospice visits were being allowed. Interview with LPN 1 on 7/26/22 at 9:30 a.m., indicated there had been some residents on the second floor of the MCU that had tested positive for COVID-19, so visitation was no longer being allowed except for hospice. She was not aware visitation could take place and was following orders from Administration. Interview with LPN 1 on 7/27/22 at 1:05 p.m., indicated visitation was shut down on the MCU on 7/19/22 at 5:15 p.m. Interview with the Administrator on 7/27/22 at 3:00 p.m., indicated they were not aware families could still visit during outbreak testing, and visitation had been reinstated as of 7/26/22. The Long Term Care (LTC) Visitation Requirement Guidelines, dated 11/22/21, indicated indoor visitation must always be allowed. Visitation was also allowed during an outbreak investigation and while a resident was in Transmission-based precautions. The length of the visit should not be limited.		accomplished for the deficient practice, is on 7/27/22 the facility immediately resumed visitation. On 8/16/22 the DON completed one on one visitations with each memory care resident to ensure no residents were affected by the discontinuation of visitation. Although the facility acknowledges that residents could have been affected by the deficient practice, none were found to be affected at that time. To ensure the deficient practice does not recur, the facility will follow the ISDH and CDC guidelines regarding visitation during COVID outbreak. The Director of Nursing and or designee will review the most current ISDH guidance weekly to ensure facility compliance utilizing an audit tool to document knowledge of updates weekly for 6 months. The date of systemic changes is 8/28/22	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The			

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	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. (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			

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	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 observation, record review, and interview, the facility failed to ensure transportation arrangements were made for an orthopedic consult for 1 of 1 residents reviewed for a fracture. (Resident F) The facility also failed to ensure the results of the State Survey were readily accessible and a notice was posted of their availability. This had the potential to affect the 216 residents who resided in the facility. Findings include: 1. On 7/26/22 at 11:29 a.m., Resident F was seated in her wheelchair in the lounge area. She had a sling to her left arm. The resident indicated her arm hurt a little bit, but she did not know how she hurt her arm. On 7/27/22 at 8:52 a.m., the resident was seated in her wheelchair in the dining room with the sling to the left arm present. At 10:13 a.m., the resident was in the lounge area and she was complaining of pain to her left arm. The record for Resident F was reviewed on 7/26/22 at 9:23 a.m. Diagnoses included, but were not limited to, dementia. The Semi Annual assessment, dated 4/5/22, indicated the resident was oriented to person with moderate cognitive impairment. The resident was extensive assistance for mobility and required total transfer assistance. The resident was at risk for falls.	R 0090	Part 1 The corrective actions that were accomplished were on 7/27/2022 DON contacted Doctors office to reschedule the appointment. The new appointment date was set for August 3rd in which the facility provided transportation. On 8/9/22 the DON and designee met with the transportation department to discuss all residents appointments dates and times. No conflicts were discovered. The measures that will be put into place to ensure the deficient practice does not recur is, a resident transportation log tool was created to monitor residents' transportations needs which will be reviewed daily by DON and transportation department 5 days a week for 6 months then weekly for 6 months to ensure deficient practice does not recur. The correction actions will be monitored by the DON and/or designee utilizing the transportation log. The date of the systemic changes will be: 8/29/2022	08/29/2022

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	Nurses' Notes, dated 7/13/22 at 8:00 a.m., indicated the resident was sitting in the common area yelling for help. The resident was guarding her left arm and was complaining of shoulder pain. No bruising was noted to the area. She had no known injury and denied falling. She was unable to lift her arm. An order was obtained to send the resident to the emergency room for evaluation. The resident returned to the facility at 3:11 p.m. with a diagnosis of a closed displaced fracture of the left humerus. New orders were received for Norco (a narcotic pain medication) 5 milligrams (mg)-325 mg, 1 tablet every 6 hours as needed (prn) for pain and follow up with the orthopedic surgeon as soon as possible. At 5:02 p.m., the resident received a dose of the prn Norco. At 5:45 p.m., the resident was in bed with her eyes closed with no signs and symptoms of pain. The next entry in the Nurses' Notes was dated 7/20/22 (no time). The note indicated the resident had an appointment scheduled with an orthopedic surgeon on 7/25/22 at 10:30 a.m., the facility would make transport arrangements and the resident's Power of Attorney (POA) was made aware. There was no further documentation in the Nurses' Notes. Interview with the Director of Nursing on 7/26/22 at 11:53 a.m., indicated the resident did not go to her appointment yesterday due to her son had knee replacement surgery and the appointment was rescheduled for August. Interview with the Administrator on 7/27/22 at 3:00		R090 Part 2- On 8/9/22 a meeting was held with administrative staff to discuss the location of the state binder. All staff were educated via meeting, email and signage. There was also a sign indicating “survey book available upon request posted at the front desk. To ensure the state survey book signage is in place, the Administarato0r will complete audits 5 days a week times 6 months using an audit tool, then weekly for 6 months. The date of the systemic changes are 8/29/22	

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	p.m., indicated she would see what she could do about getting the resident seen sooner by the orthopedic surgeon since no follow up had been completed since the resident was seen in the emergency room. 2. During the Environmental tour on 7/26/22 at 1:55 p.m. through 2:25 p.m., the State Survey results were not observed to be available and there was no sign posted anywhere in the facility indicating the location of the survey results. Interview with the Maintenance Director on 7/26/22 at 2:25 p.m., indicated he was not sure where the State Survey information was located. Interview with Employee 1, who was working at the front desk, on 7/26/22 at 2:26 p.m., indicated she was a new employee and was not sure where the State Survey information was located. She was not aware of any signs posted that would inform the residents where they could find the State Survey information. She would ask Employee 2. Interview with Employee 2 on 7/26/22 at 2:30 p.m., indicated she was not sure where the State Survey information was located but she would ask. She went in the office behind the front desk and returned with the State Survey results binder. She indicated the book was usually kept on a shelf in the front office. She was not aware of any signs posted that would inform the residents where they could find the State Survey information.			
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are			

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	attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on observation, record review and interview, the facility failed to implement the Fall Management policy, related to lack of a thorough post fall investigation for 3 of 3 residents reviewed for implementation of the Fall Management policy. (Residents F, B, and E) Findings include: 1. On 7/26/22 at 11:29 a.m., Resident F was seated in her wheelchair in the lounge area. She had a sling to her left arm. The resident indicated her arm hurt a little bit, but she did not know how she hurt her arm. On 7/27/22 at 8:52 a.m., the resident was seated in her wheelchair in the dining room with the sling to the left arm present. At 10:13 a.m., the resident was in the lounge area and she was complaining of pain to her left arm. The record for Resident F was reviewed on 7/26/22 at 9:23 a.m. Diagnoses included, but were not limited to, dementia. The Semi Annual assessment, dated 4/5/22, indicated the resident was oriented to person with moderate cognitive impairment. The resident was extensive assistance for mobility and required total transfer assistance. The resident was at risk for falls. Nurses' Notes, dated 7/13/22 at 8:00 a.m., indicated	R 0091	The corrective actions that were accomplished for Resident E- The Director of Nursing submitted the incident report to the ISDH. The DON retrieved statements from the staff on duty on 7/13/22 in efforts to retrieve more information to determine the possible cause. No additional supportive information was received. On 8/27/22 An educational in-service will be completed with the director of Nursing and Unit Manager to review and discuss the Fall Management Policy, Fall investigation protocol, and the auditing process to ensure the facility/s policies are being followed. Also, on 8/25/2022- the incident report and fall investigation report was revised to reflect a detailed in-depth investigation to provide additional information including retrieving statements. The systemic measures put into place to ensure the deficient practice does not recur is: A monthly fall log form was created to log and audit all falls, incidents, and unusual occurrences to monitor the correct	08/28/2022

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	the resident was sitting in the common area yelling for help. The resident was guarding her left arm and was complaining of shoulder pain. No bruising was noted to the area. She had no known injury and denied falling. She was unable to lift her arm. An order was obtained to send the resident to the emergency room for evaluation. The resident returned to the facility at 3:11 p.m. with a diagnosis of a closed displaced fracture of the left humerus. The Fall Investigation form, dated 7/14/22, indicated the resident did not know how she hurt her arm. The investigation lacked staff interviews and what the resident was doing prior to her complaints of arm pain. There was no documentation of a possible root cause of the injury. Interview with the Administrator on 7/27/22 at 3:00 p.m., indicated the investigation did not provide enough detail for a root cause analysis and she also indicated the investigation form could use some revision to provide more detail. 2. The record for Resident B was reviewed on 7/27/22 at 9:04 a.m. Diagnoses included, but were not limited to, delusional disorder and depression. The Service Plan, dated 4/5/22, indicated the resident was oriented to person with moderate impairment. She required moderate assistance with ambulation and transfers and was at risk for falls. Nurses' Notes, dated 6/29/22 at 4:45 p.m., indicated the resident was observed on the floor with blood coming from the back of her head. Upon assessment, the resident had a laceration to		follow up in accordance with ISDH guidelines. The log will be reviewed weekly for 12 months by the Director of Nursing and/or designee. The date of systemic changes is 8/28/22 Resident B- The corrective action that occurred was an order was received by the attending physician to remove the staples. The family and resident were notified. The DON and designee completed an audit of all residents charts and physician orders to ensure all orders were received for treatments. Resident E- On 7/27/22 The physician and family were notified of the fall and discoloration. The incident was reported to ISDH on 7/27/2022. The fall investigation was also completed. Thee measures put into place to ensure the deficient practice does not recur is. On 8/15/22 An educational in-service was completed with the director of Nursing and Unit Manager to review and discuss the Fall Management Policy, Fall investigation process, and the auditing process to ensure the facility/s policies are being following. On 8/25/22 an all-staff educational in-service will be	

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	the back of her head with active bleeding. 911 was called and the resident was transported to the hospital. At 4:56 p.m., the Nurse Practitioner (NP), the resident's Responsible Party and the Director of Nursing were notified of the laceration. At 8:10 p.m., the resident returned from the emergency room with 4 staples to the back of the head. Documentation indicated no new orders were given and staff would continue to monitor. The Fall Investigation form, dated 6/29/22, indicated an environmental audit was conducted and no hazards were noted. The conclusion and action plan indicated the resident possibly tripped over her feet. The resident was encouraged to request staff assist for transfers. The investigation lacked staff interviews and what the resident was doing prior to being found on the floor. Interview with the Administrator on 7/27/22 at 3:00 p.m., indicated the investigation did not provide enough detail for a thorough root cause analysis and she also indicated the investigation form could use some revision to provide more detail.3. On 7/26/22 at 11:20 a.m., Resident E was observed to have discoloration to her right eye orbital area and fading discoloration to her left forearm. Interview with the resident at that time, indicated she woke up one morning about a week ago and noticed the eye discoloration. She did not recall how it happened. The record for Resident E was reviewed on 7/25/22 at 1:00 p.m. Diagnoses included, but were not limited to, lung cancer and heart disease. A Nurse's Note, dated 7/18/22 at 6:00 p.m., indicated, the resident was sitting on the floor in		conducted by the director of Nursing and or/designee to review the informational to ensure understanding and compliance of the community's policy. The corrective actions will be monitored to ensure a monthly fall log/ unusual occurrence. form was created to log and audit all falls, incidents, and unusual occurrences and investigation to monitor the correct follow up in accordance with ISDH guidelines. The log will be reviewed twice weekly for 12 months by the Director of Nursing and/or designee. The date of systemic changed is 8/28/22	

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	front of her chair. She indicated she fell but she wasn't able to elaborate any further details. No bruises were noted and a scratch was present on the left upper thigh. There was no documentation indicating the Physician or the Director of Nursing (DON) was notified of the fall. A message was left for the resident's daughter at 10:00 p.m. A Nurse's Note, dated 7/21/22 at 8:00 a.m., indicated, the "resident's caregiver reported discoloration to L [left] outer eyelid and orbital. Also has discoloration to L elbow. Denies pain or discomfort. Currently on Plavix [a blood thinner] 75 milligrams [mg] . Daily communication forwarded to Dr. [Physician's name], family notified." There was no documentation the DON had been notified of the discoloration. Interview with the Director of Nursing on 7/26/22 at 2:15 p.m., indicated she was unaware of the resident having a "black eye" as of 7/21/22 so she had not conducted an investigation. At 2:38 p.m., the DON indicated she had spoken with the resident who told her she thought she may have rolled against the wall while sleeping in her recliner. The DON indicated the Unit Manager was aware of the incident but had not relayed the information to her. The current Fall Management Handbook was provided by the Administrator on 7/27/2022. The policy indicated a fall investigation should be completed within 48 hours of the fall event. This state residential finding relates to Complaint IN00384290.			

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R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on record review and interview, the facility failed to ensure a temporary nurse aide (TNA) was not working past 7/1/22 after the emergency waiver had expired for 1 of 1 TNA's reviewed. (TNA 1) Finding includes: The Employee Files were reviewed on 7/27/22 at 2:15 p.m. TNA 1 was hired on 5/6/22. She received a TNA certificate of completion on 5/7/22. The TNA worked at the facility providing care to residents on 7/6, 7/7, 7/12, 7/15, 7/16, 7/18, and 7/19/22. An Indiana Department of Health LTC Newsletter 2022-21, dated May 19, 2022, indicated "The emergency orders and waivers allowing personal care attendants [PCA's] and temporary nurse aides [TNA's] expire on July 1. Facilities are encouraged to complete the training of their PCA's, TNA's and others working as nurse aides by that date. Nurse aide training programs have until July 1 to train nurse aides using the expedited training - that training is only allowed under the waivers under the emergency orders that expire July 1. Any nurse aide training after	R 0118	The corrective action to be accomplished for the deficient practice is: the TNA was immediately removed from the schedule and offered a position in a different department in which she declined. The facility identified other residents/employees having the potential to be affected by the deficient practice is on 8/23/22 an audit of all nurses, QMA's and CNA's licenses was conducted by HR to ensure proper licensure per ISDH guidelines. Thee facility recognizes the potential for other residents to be affected by the deficient practice however, none were noted to be found at that time. The measures put into place to ensure the deficient practice does not recur is an monthly audit of all clinical staff members will be completed for 12 months by Human Resources and/or	08/22/2022

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	July 1 must be the usual 105 hours of training." Interview with the Administrator on 7/27/22 at 4:00 p.m., indicated she was aware the emergency waiver had expired on 7/1/22.		designee to ensure the deficient practice does not recur. The date of the systemic changes is 8/22/22	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, record review, and interview, the facility failed to ensure a resident had the ability to self-administer medications for 1 of 1 residents reviewed for medications at the bedside. (Resident E) Finding includes: During an interview with Resident E on 7/26/22 at 11:20 a.m., an Albuterol inhaler was observed on the resident's dining table. Another Albuterol inhaler and a Trelegy (Fluticasone) discus were observed on the bookshelf in the corner of the room. The resident indicated she had gotten the medications from her Physician. One of the Albuterol inhalers was a sample and the other	R 0216	The corrective actions completed for Resident E is on 8/23/22 an self-medication administration test was completed per resident request. Physicians' orders were received for residents to self-administer inhalers and nebulizers. On 8/20/22, the DON and unit manager completed an audit of all residents' rooms to ensure the proper medication storage and self-administration procedures. The measures that will be put into place to ensure the deficient practice does not recur: On	08/25/2022

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	inhalers were prescribed. The record for Resident E was reviewed on 7/25/22 at 1:00 p.m. Diagnoses included, but were not limited to, lung cancer and heart disease. The resident's current Service Plan indicated she was cognitively intact. The July 2022 Physician's Order Summary (POS), indicated the resident did not have an order to self-administer her medications. There was also no Self-Administration of Medication evaluation available for review. Interview with RN 1 on 7/25/22 at approximately 11:00 a.m., indicated the resident did not self administer her medications.		8/22/22 the facility sent out a letter to families discouraging medication delivery to residents' rooms who fail to have self-administration orders per the attending physician. Also all service care plans were reviewed to ensure all residents who self-administered medications were in compliance with thee community's policy's and ISDH regulations. Although the facility recognizes other residents may have been affected by this deficient practice, none were noted at that time, The corrective actions put into place is: 2 times per week (30 apartments) for 6 months an audit will be conducted by the Director of Nursing and/or Designee utilizing an audit tool to monitor the completion of environmental audits and self admin service care plan reviews to ensure medication compliance in accordance with ISDH regulations and the facility's policy. The date of systemic changes is 8/25/22	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, record review, and interview, the facility failed to provide necessary services to assist with personal care and activities	R 0240	The corrective actions that were accomplished for resident 2: The bolster order was discontinued per	08/31/2022

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	of daily living related to a wheelchair bolster for positioning and applying lotion for skin care for 1 of 13 sampled residents. (Resident 2) Finding includes: On 7/26/22 at 11:50 a.m., Resident 2 was observed sitting in her wheelchair participating in activities. She was leaning forward and to the left side. There was no bolster noted to her wheelchair on the left side. During an interview with the resident on 7/27/22 at 9:00 a.m., she indicated staff were not applying any lotion on her legs. The Home Health Nurse informed the resident her wounds on her legs were almost healed and the facility staff were to put lotion on her legs. At that time, the resident's arm was observed dangling on the side of the wheelchair. There was no wheelchair bolster noted to the chair to support the arm. On 7/27/22 at 10:30 a.m., the resident was observed sitting in a circle with other residents participating in activities. She was leaning slightly forward and to the left side, and there was no bolster noted in her wheelchair on the left side. Interview with CNA 1 and CNA 2 on 7/27/22 at 10:35 a.m., indicated they both got the resident up this morning. CNA 2 indicated the resident couldn't walk, but would stand and pivot to get into the wheelchair. Neither one of them were aware the resident was supposed to have a wheelchair bolster in her chair to support her left side. The record for Resident 2 was reviewed on 7/26/22 at 9:20 a.m. Diagnoses included, but were not limited to, stroke and left side hemiparesis (muscle		resident request. On 8/16/22 the Director of Nursing completed a complete audit of all treatments and care plans to ensure all orders and interventions were in place. None were noted to be affected by the deficient/ practice at that time. The Director of Nursing also conducted a meeting with One Home Health to discuss proper procedures when transcribing orders. On 8/26/22, an all staff educational in-service was conducted to discuss ensuring all treatments, orders and interventions are in place per physician orders. To prevent the deficient practice does not recur, the Director of Nursing and or/designee will be completing audits of all physicians orders using an audit tool daily for 6 months to ensure interventions, and order compliance and comparing compliance and accuracy por service care pplans. The date of the systemic changes is 8/31/22	

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	weakness) Physician's Orders, on the current 7/2022 Physician Order Statement, indicated wheelchair bolster to the left side of the wheelchair. The 7/2022 Treatment Administration Record (TAR) indicated the wheelchair bolster was an "FYI" (for your information) for nursing staff. Nurses' Notes, dated 7/22/22 at 1:00 p.m., indicated the Home Health Nurse saw the resident. A new order for ted hose (antiembolytic stockings) and to apply lotion to legs daily was obtained. There was no Physician's Orders for the ted hose or the lotion. There was no documentation on the 7/2022 TAR for the ted hose or for the lotion to be applied daily. Interview with RN 1 on 7/27/22 at 10:25 a.m., indicated the Home Health Nurse was taking care of ordering the ted hose for the resident and they had not been delivered. She indicated there should have been an order for lotion and the ted hose, however, she had forgotten to write the order. Interview with the Director of Nursing on 7/27/22 at 4:00 p.m., indicated the resident should have had the wheelchair bolster in her chair.			
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment			

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	records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on record review and interview, the facility failed to ensure medications were signed out as ordered for 1 of 10 residents reviewed for medication administration. (Resident F) Finding includes: The record for Resident F was reviewed on 7/26/22 at 9:23 a.m. Diagnoses included, but were not limited to, dementia. The July 2022 Physician's Order Summary (POS), indicated the resident was to receive Clonidine (a blood pressure medication) 0.1 mg/24 hour patch, apply one patch topically every week on Thursday, Vitamin D capsule 5000 units, take 1 capsule every week on Thursday, and Aspercreme pad 4%, apply one patch topically to the knee daily on for 12 hours and off for 12 hours. The May 2022 Medication Administration Record (MAR), indicated the Clonidine patch was not signed out as being applied on 5/26/22. The Vitamin D capsule was not signed out as being given on 5/26 and the Aspercreme pad 4% was not signed out as being applied on 5/20, 5/23, 5/27, 5/28, 5/29 and 5/31/22. Interview with the Administrator on 7/27/22 at 3:00 p.m., indicated the medications should have been signed out as ordered. This state residential finding relates to Complaint	R 0243	The corrective actions that were accomplished is an all staff nursing in-service is scheduled for 8/25/22 to review all medication records noted to have missing signatures fir June and July by Director of Nursing and Designee utilizing an audit tool. Staff completed statements indicating all medications were administered even though they failed to sign out as given, will be accomplished is an educational in-service is scheduled to be conducted on 8/25/22 to discuss legal documentation as it relates to medication administration. To determine if other residents were affected by the deficient practice is: he Director of Nursing and/or Designee completed an audit of all medication administration records in residents charts as well as the August MAR. All concerns were noted and discussed with the nurses and QMA's. The Director of Nursing and/or designee will be completing weekly meetings weekly for 12 months utilizing an audit tool to discuss medication	08/26/2022

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	IN00381495.		documentation and compliance to ensure the deficient practice does not recur . The meeting and compliance will be monitored utilizing an audit tool. The date of the systemic changes will be 8/26/22.	
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on record review and interview, the facility failed to ensure the Registered Dietitian's (RD) recommendations were followed in a timely manner for a resident with a history of weight loss for 1 of 13 sampled residents. (Resident 4) Finding includes: The record for Resident 4 was reviewed on 7/25/22 at 1:00 p.m. Diagnoses included, but were not limited to, chronic kidney disease, dementia, type 2 diabetes, and depression. The Service Plan, dated 4/13/22, indicated the resident was receiving Hospice services and was to be weighed three times a week due to a recent weight loss. Physician's Orders, dated 7/12/22, indicated to obtain weight on Monday, Wednesday, and Friday. An RD Note, dated 7/15/22, indicated a monthly weight of 157 pounds, weight down 9 pounds in one month. The resident received a no concentrated sweets diet and all vitamins and	R 0275	The corrective action to be accomplished for Resident F is; a meeting was held on 8/10/22 with the dietician to discuss the order. As attached to this plan of correction the dietician stated in the attached letter that the chart was not available at the time and The RD did not include the recommendation, intended to send the report separately but inadvertently forgot to communication the notation in the chart and failed to notify staff that the insert had been placed in the chart. The corrective action to be accomplished for Resident F is an audit of all dietary notes (utilizing an audit tool) in the chart to ensure the dietician did not fail to communicate any other order. No other residents aware noted to be affected by the deficient practice at that time. The dietician also	08/22/2022

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	minerals had been discontinued per Hospice. In light of the weight decrease, the resident may benefit from supplementation with 90 milliliters of Med Pass 2.0 three times a day, to better meet nutritional needs. Interview with the Director of Nursing (DON) on 7/27/22 at 10:00 a.m., indicated she had put the order in for the resident to be weighed three times a week because he had been losing weight. She was unaware the RD had recommended the Med Pass for a nutritional supplement. She thought he was already receiving Med Pass. Interview with the DON on 7/27/22 at 5:00 p.m., indicated the RD report, dated 7/15/22, lacked documentation of the recommendation to start the Med Pass supplement for the resident.		stated in the attached letter that the insert was NOT an order. The systemic changes put into place to ensure the deficient practice does not recur is; The dietician and facility has an written agreement in pace that all dietary recommendations will be submitted in a dietary recommendation report. The report will be monitored by the Director of Nursing/and or designee monthly for 12 months. Th date of the systemic changes will be 8/22/22.	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on observation, record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to follow up documentation after a hospital visit, documentation of bruising, skin tears, and abrasions, and clarification of the ability to consume alcohol for 4 of 13 sampled residents. (Residents F, D, C, and G)	R 0349	The corrective action to be accomplished for Resident F is that an educational in-service is scheduled for all nursing staff on 08/25/22 to further discuss proper documentation related to skin discolorations , service care plan revision and compliance with implementing change of care on	08/30/2022

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	Findings include: 1. The record for Resident F was reviewed on 7/26/22 at 9:23 a.m. Diagnoses included, but were not limited to, dementia. The Semi Annual assessment, dated 4/5/22, indicated the resident was oriented to person with moderate cognitive impairment. The resident was extensive assistance for mobility and required total transfer assistance. The resident was at risk for falls. Nurses' Notes, dated 7/13/22 at 8:00 a.m., indicated the resident was sitting in the common area yelling for help. The resident was guarding her left arm and was complaining of shoulder pain. No bruising was noted to the area. She had no known injury and denied falling. She was unable to lift her arm. An order was obtained to send the resident to the emergency room for evaluation. At 3:11 p.m., the resident returned from the hospital via ambulance. She was diagnosed with a closed displaced fracture of the left humerus. At 5:02 p.m., the resident was medicated for pain. At 5:45 p.m., the resident was in her bed with her eyes closed and she had no signs and symptoms of pain. The next entry in the Nurses' Notes was on 7/20/22 (no time), indicating the resident had an appointment scheduled with the orthopedic surgeon on 7/25/22 at 10:30 a.m. and the facility would make transport arrangements. There was no further documentation in the Nurses' Notes after 7/20/22.		the 24hr report. The Director of nursing and /or designee completed an audit of all the resident skin sheets as charts as well as the 24 hr. report for the last 30 days. No other residents were noted to be affected by this deficient practice at this time. The Director of Nursing and/or designee will complete an education with all nursing staff on 8-25-22 educating nurses regarding all unusual occurrences remains on charting until the issue is resolved. The Director of Nursing and /or designee will review alert charting nurses notes 5 days per week for 6 months utilizing an audit tool to ensure the deficient practice does not recur. The date the systemic changes will be 8/30/22. The corrective Action to be accomplished for resident D is that the residents nurses note was updated to reflect the discoloration to the left shin. The service care plan was also revised. Family and attending physician was notified. The an educational in-service is scheduled for all nursing staff on 8-25-22 to further discuss legal and proper documentation in relate	

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	Interview with LPN 1 on 7/26/22 at 10:26 a.m., indicated if a resident was on charting, it was added to the 24 hour report. She indicated the resident was currently not on charting. Interview with the Administrator on 7/27/22 at 3:00 p.m., indicated follow up documentation should have been completed for at least 72 hours after the resident returned from the emergency room. 2. On 7/26/22 at 11:29 a.m., Resident D was seated in a broda chair in the lounge area. A large area of reddish/purple discoloration was observed on the resident's left shin. The record for Resident D was reviewed on 7/26/22 at 10:28 a.m. Diagnoses included, but were not limited to, dementia and anorexia. The Service Plan, dated 4/5/22, indicated the resident was cognitively impaired for daily decision making and was dependent on staff for transfers. The resident was identified as receiving hospice services. Nurses' Notes for the month of July 2022, indicated there was no documentation related to the discoloration to the resident's left shin. Interview with the Director of Nursing on 7/27/22 at 8:45 a.m., indicated documentation should have been completed related to the shin discoloration. 3. During a random observation on 7/25/22 at 10:00 a.m., Resident C was observed sitting in a wheelchair in her room watching television. RN 1 was asked to open the resident's refrigerator. At that time, there was an open bottle of champagne, 2 bottles of malt liquor, 1 can of beer, and 1 can of a vodka seltzer.		to failing to document skin discolorations. The facility identified other residents having the potential to be affected by the efficient practice by completing a skin assessment during the scheduled shower days. None were found to be affected at that time. The measures put into place to ensure the deficient practice does not recur is: An educational in-service is scheduled for all nursing staff on 8-25-22 to further discuss legal and proper documentation in relation to skin discolorations and concerns. The systemic changes that were put into place is: The Director of Nursing and or Designee will monitor skin/shower sheets 3 times per week for 6 months then 2 times per week for 4 months to monitor any changes in skin conditions. The date of the systemic changes will be completed will be 8/30/22. The corrective action for Resident G is the clinical record and service care plan was revised to reflect the skin concern/laceration. The family and attending physician was notified and orders were received to treat the laceration. The service care plan was updated to reflect the treatment. The facility identified other	

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	Interview with RN 1 at that time, indicated she was unaware the alcohol was in the refrigerator. She indicated the resident's son must have brought it in for the resident. The record for Resident C was reviewed on 7/26/22 at 10:05 a.m. Diagnoses included, but were not limited to, dementia with behaviors, depressive disorder, and restlessness and agitation. Physician's Orders, dated 6/22/22, indicated the resident was admitted to hospice. Physician's Orders, dated 6/28/22, indicated Seroquel (an antipsychotic medication) 100 milligrams (mg) before meals and 75 mg at bed time. Physician's Orders, dated 7/5/22, indicated Lorazepam (an anti-anxiety medication) 1 mg three times a day. Physician's Orders, dated 6/28/22, indicated Sertraline (an antidepressant medication) 100 mg daily. The 2/2022, 3/2022, 4/2022, and 7/2022 Physician's Orders Statement (POS) indicated, "Resident may receive alcoholic beverages Yes or No." Neither Yes or No was checked. The 6/17- 6/30/22 (POS), indicated the "No" was checked if the resident could receive alcoholic beverages. The Service Plan, dated 6/28/22, indicated the resident had been admitted to hospice. There was no information on the Service Plan if the resident		residents who may have the been affected by the deficient practice is the week of 8/21/22 the Director of Nursing and designee completed an audit of skin assessment forms during the residents scheduled shower days. None were found to be affected at that time. The measures put into place to ensure the deficient practice does not recur is: An educational in-service is scheduled for all nursing staff on 8-25-22 to further discuss legal and proper documentation, proper physician order retrieval and transcription. The measures put into place to ensure the deficient practice does not recur is the Director of Nursing and/or designee will complete weekly audits of all resident's skin sheets reflecting concerns in comparison with physician orders utilizing an audit tool. The audits will be conducted by the Director of Nursing and/or designee on all residents shower sheets who receive shower assistance weekly for 52 weeks. The date of the systemic changes will be completed will be 8/30/2022.	

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	could consume alcohol. Interview with the Director of Nursing (DON) on 7/27/22 at 8:45 a.m., indicated she was unaware the resident had any alcohol in her refrigerator. Interview with the Administrator on 7/27/22 at 3:00 p.m., indicated the resident was known to her and she could have alcohol, however, she was unaware there was no Physician's Order for the alcohol nor was it on her Service Plan. 4. The record for Resident G was reviewed on 7/27/22 at 9:33 a.m. Diagnoses included, but were not limited to, anxiety, dementia, and altered mental status. The resident was admitted to the facility on 5/11/22. Nurses' Notes, dated 5/14/22 at 6:30 p.m., indicated care staff called the writer into the resident's room at 5:30 p.m. The resident was observed lying on her back on the floor with blood on the carpet and in her hair. The resident was alert and verbal, with complaints of pain to her back, right hip and head. There was a laceration noted to the side of her head with a moderate amount of bleeding. The ambulance service was called and the resident was taken to the hospital. Physician's Orders, dated 5/14/22, indicated laceration to the forehead due to fall, send to emergency room. The resident was admitted to the hospital on 5/14 and returned on 5/17/22. Nurses' Notes, dated 5/17/22 a 2:20 p.m., indicated the resident returned from the hospital and an abrasion was observed to the right side of her			

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	head with some discoloration observed. The resident also had a skin tear to the left inner arm. Nurses' Notes dated 5/17/22 at 7:00 p.m., 5/17 (no time), 5/18 at 2:00 p.m., 5/19 at 1:15 p.m., 5/19 at 8:10 p.m., 5/20 at 5:00 p.m., 5/21 at 5:00 a.m., indicated there was no documentation or an assessment of the abrasion to the forehead or the skin tear. Nurses' Notes, dated 7/14/22 at 2:58 p.m., indicated the resident was found sitting at the foot of the bed on the floor. There was a small laceration observed to her right wrist. The area was cleansed with normal saline and triple antibiotic ointment was applied with a dry bandage. There was no other documentation or an assessment of the laceration on the resident's right wrist. There were no Physician's Orders for a treatment and there was no documentation other treatments had been completed for the laceration. Interview with RN 1 on 7/27/22 at 10:30 a.m., indicated there was no Physician's Order for the treatment to the laceration to the right wrist. This state residential finding relates to Complaints IN00379284 and IN00384290.			
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms.			

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	(2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on random observations, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to glove use, improper mask use, the lack of COVID-19 monitoring and testing, and not placing an unvaccinated resident in isolation upon admission for 4 of 13 sampled residents. (Residents 4, G, C, and 2) Findings include: 1. During a random observation, on 7/26/22 at 9:14 a.m., CNA 3 was walking down the hallway wearing a pair of disposable gloves. Interview with the CNA at that time, indicated she didn't want to touch anything due to COVID. She was not aware that she couldn't wear gloves in the hallway. 2. During a random observation on 7/26/22 at 11:29 a.m., Activity Assistant 1 was providing nail care for a resident in the Memory Care Unit (MCU) lounge. She had her KN95 mask pulled down below her nose and mouth and was talking to the resident. The resident was not wearing a mask either. At 1:19 p.m., the Activity Assistant again had her mask pulled down while performing nail care for the same resident. The resident was not wearing a	R 0407	R407 The corrective action that was accomplished for CNA3 is: CAN 3 was educated regarding infection control and proper glove disposal. The corrective action for Activity Assistant 1 is: she receives immediate written education regarding proper mask use and infection control. The corrective action for laundry employee 1 is laundry employee received immediate education regarding proper mask use and infection control. The corrective action taken for Dietary 1 is: the dietary employee received immediate written education and in-servicing regarding proper mask use and infection control. The DON and Administrator completed a facility wide audit of employee infection control compliance on 7/27/22 to determine if others were affected by the deficient practice. None were noted to be affected at that time. The measures put into place to ensure the deficient practice does not recur is, on 7/28/22 an all-staff education was completed covering	08/30/2022

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	mask either. Interview with the Activity Assistant at that time, indicated she had her mask pulled down so the resident could hear her. 3. During a random observation on 7/26/22 at 1:33 p.m., Laundry Employee 1 was pushing a laundry cart on the first floor of the MCU and waiting for the elevator. She was not wearing a mask. There were two residents in the lounge area, located by the elevator. The residents in the lounge area were not wearing masks. Interview with the employee at that time, indicated she didn't have a mask and would have to find one. She then proceeded to the Nurses' Station and asked for a mask. 4. On 7/26/22 at 1:30 p.m., Dietary Employee 1 was wearing gloves in the hallway and carrying a disinfectant bucket. He wiped down the tables in the dining room on the first floor of the MCU. He then proceeded upstairs with the bucket and continued to wear the gloves. He returned to the first floor with the tray cart and was still wearing the disposable gloves. 5. The record for Resident 4 was reviewed on 7/25/22 at 1:00 p.m. Diagnoses included, but were not limited to, chronic kidney disease, dementia, type 2 diabetes, and depression. The Service Plan, dated 4/13/22, indicated the resident was receiving Hospice services. The resident received a COVID-19 vaccine on 1/28/21 and a second dose on 3/1/21. A booster was administered on 11/11/21. The resident was admitted to the hospital on		infection control, mask use and proper mask wear. The corrective actions and systemic changes put into place is a month educational communication will be completed each month for 6 months to review infection control, mask use and proper glove wear and will be monitored by the Administrator. The date of the systemic changes is 8/30/22 The corrective action for Resident 4 is the resident was tested for COVID 19. Results were negative. On 7/28/22 an audit was completed of all residents who were admitted on returned from the hospital in July 2022. All residents affected by the deficient practice was COVID tested at that time. The measures put into place to prevent the deficient practice from recurring was an all-staff education regarding COVID testing upon admission and hospital return. The director of nursing, medical records liaison and /or designee will review each hospital admission utilizing an audit tool for 6 months to ensure compliance. The date of the systemic changed are 8/30/22 R407 The corrective action for resident G -the resident was placed in isolation.	

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	5/11/22 and returned to the facility on 5/13/22. He had another hospital admission and returned to the facility on 6/9/22. There was no documentation for both readmissions regarding if the resident was tested immediately for COVID-19 and then 5 to 7 days later. There was no documentation the resident was screened daily for COVID-19, which included a temperature and pulse oximetry. Interview with the Director of Nursing on 7/27/22 at 10:00 a.m., indicated there was no documentation the resident was tested for COVID-19 on readmission in May and June 2022. 6. The record for Resident G was reviewed on 7/27/22 at 9:33 a.m. Diagnoses included, but were not limited to, anxiety, dementia, altered mental status, and severe malnutrition. The resident was admitted to the facility on 5/11/22. There was no documentation indicating the resident was vaccinated for COVID-19. There were no Physician's Orders to indicate the resident was placed in quarantine as a new admission as a standard precaution to prevent the spread of COVID-19. There was no documentation the resident was placed in droplet/contact isolation for COVID-19 or was tested for COVID-19 at the time of admission and then again 5 to 7 days later. The resident was sent to the hospital on 5/14/22 and returned on 5/17/22. There was no documentation the resident was placed in isolation or tested for COVID-19 at the time of		On 8/25/22an audit was completed by the director of nursing to determine any resident was not vaccinated and not in quarantine. None were found to be affected at that time. The measures put into place to ensure the deficient practice does not recur is: an COVID vaccination audit was completed of all residents charts on 8/22/22to determine which residents were vaccinated. All residents who were not vaccinated were placed on a quarantine notification log to alert staff to initiate isolation upon a return from the hospital. This will be monitored daily for 6 months by the Director of Nursing and/or designee. An all-nursing staff in-service was conducted on 8/22/22 to educate nurses regarding proper quarantine protocols and retesting residents upon hospital returns. The date of systemic changes are 8/30/22	

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	readmission or 5 to 7 days later. Interview with RN 1 on 7/27/22 at 10:30 a.m., indicated there was no documentation the resident was tested for COVID-19 at the time of admission, readmission, and then 5 to 7 days after. There was no documentation the resident was placed in isolation for either admission. Interview with Administrator on 7/27/22 at 2:30 p.m., indicated the resident was not vaccinated and should have been in quarantine for 10 days at the time of admission and when she was readmitted on 5/17/22. 7. The record for Resident C was reviewed on 7/26/22 at 10:05 a.m. Diagnoses included, but were not limited to, dementia with behaviors, depressive disorders, and restlessness and agitation. Nurses' Notes, dated 4/28/22, indicated the resident was observed with vaginal bleeding and was admitted to the hospital. The resident went to a long term care facility for rehabilitation and returned to the facility on 6/17/22. The resident received a COVID-19 vaccine 1/29/21 and 2/20/21. A booster was administered on 12/14/21. Nurses' Notes, dated 6/17/22, indicated "...COVID-19 negative at this time." There was no documentation if the resident was tested for COVID-19 5 to 7 days after readmission. There was no documentation the resident was screened daily for COVID-19 which included a temperature and pulse oximetry.			

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	Interview with the Director of Nursing (DON) on 7/27/22 at 10:00 a.m., indicated there was no documentation the resident was tested for COVID-19 5 to 7 days after readmission. Interview with the DON on 7/27/22 at 11:55 a.m., indicated she had no documentation of daily screening for COVID-19 for those residents who resided in the green zone. The CNA's used to take the resident's temperature daily, however it had not been completed in the last 2 months of June and July 2022. The updated 2/8/22, "LTC COVID-19 Clinical Guidance", indicated "Screen all residents daily for fever and for COVID-19 symptoms. Ideally, include an assessment of oxygen saturation via pulse oximetry. New admissions/re-admissions if not up to date on COVID-19 vaccination should be observed in TBP, yellow zone for 10 days. COVID-19 vaccination should also be offered. They should be moved to red zone if confirmed positive for COVID -19. They can be released to green zone after 10 days if asymptomatic." The LTC Newsletter 2022-28 July 14, 2022, indicated "Residents who leave the facility for 24 hours or longer should generally be managed as a new admission/readmission, and the same guidance applies. 1. For all new admissions, be sure to get good interfacility communication on close contacts and symptoms. 2. All new admissions should have a series of two viral tests: the first test at 24 hours after admission and, if negative, a second test 5-7 days after their admission. They should be watched for symptoms daily. 3. New admissions who are asymptomatic, not a			

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	close contact and are up-to-date do not need to be quarantined. 4. A new admission individual can come out of quarantine after receiving a booster without any waiting period as long as they meet all the following requirements: Had no close contact (with a reliable history); Not an immunocompromised individual; and Not symptomatic" 8. During a random observation on 7/25/22 at 10:15 a.m., Physical Therapy Assistant (PTA) 1 was observed in the therapy room standing within 2 feet of a resident with no face mask on. She was providing therapy for the resident. The resident was also not wearing a face mask. During a random observation on 7/26/22 at 10:58 a.m., PTA 1 was observed walking down C hall and near other residents with her face mask below her nose. She walked to a resident's room and assisted the resident down the hall with her face mask still below her nose. Interview with PTA 1 at that time, indicated she was aware she needed to wear a face mask at all times when around residents. 9. The record for Resident 2 was reviewed on 7/26/22 at 9:20 a.m. Diagnoses included, but were not limited to, stroke and left side hemiparesis (muscle weakness) A 72 Hour Alert Charting assessment indicated on 5/16/22, the resident tested positive for COVID-19. The resident's temperature, blood pressure, pulse and respirations were obtained on night, day, and evening shifts on 5/17 and 5/18/22. There was no assessment of the resident's lung sounds or an oxygen saturation assessment.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Nurses' Notes, dated 5/16-5/26/22, indicated there was no documentation of increased monitoring, which included a full set of vital signs, a respiratory assessment of the lungs, and pulse oximetry while positive for COVID-19. Interview with the Director of Nursing on 7/27/22 at 4:00 p.m., indicated she was aware when residents' tested positive for COVID-19 they were to be monitored more frequently. The updated 2/8/22, "LTC COVID-19 Clinical Guidance", indicated "Increase monitoring of residents with known COVID-19 including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam to identify and quickly manage serious infection."			