STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 00 B. WING	06/17/2021

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AUTUMN RIDGE REHABILITATION CENTRE	600 WASHINGTON AVE WABASH, IN 46992

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 13, 14, 15, 16 and 17, 2021. Facility number: 000081 Provider number: 155162 AIM number: 100289570 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type: Medicare: 2 Medicaid: 36 Other: 13 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 23, 2021.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey revisit.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or			

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

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	enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record review, the facility failed to provide privacy for a resident who was cognitively impaired for 1 of 21 residents reviewed for dignity (Resident 31). Findings include: Observations of Resident 31, included but were not limited to, the following:	F 0550	**F 550 Resident Rights** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: · **Resident 31 bed location has been changed to position B, utilizing center privacy curtain, to prevent possible**	07/12/2021

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	On 6/13/21 at 12:30 p.m., the resident laid in bed on her back with her knees bent, she was uncovered and naked from the waist down, her buttocks and peri-area was exposed to the hallway. A male resident in a powerchair propelled himself passed her room during the observation. On 6/13/21 at 12:33 p.m., SSD (Social Service Designee) walked by the resident's room she paused near the resident's doorway and went to answer a call light down the hall. On 6/13/21 at 12:42 p.m., SSD walked by the residents's room with a tray in her hand, she placed the tray on the meal cart and walked to the other end of the hall. During an interview on 6/13/21 at 12:44 p.m., QMA 23 indicated she thought the resident was careplanned to be that way, she could go in and attempt to cover her, but she may not stay that way. On 6/14/21 at 3:20 p.m., the resident was standing at her over bed table in her room and was drinking water from her water pitcher, she had a shirt on with no pants and her buttocks were exposed, the DON walked by her room and then came back to her room, she asked the resident if she was done with her tray and removed the tray from her room and pulled her door partially closed. On 6/17/21 at 9:47 a.m., QMA 23 left the residents room and partially closed the residents door, the resident then got up with just her shirt on and opened the door, laid back in bed on her back with her knees bent and exposed her buttocks and peri-area to the hallway. On 6/17/21 at 10:14 a.m., Housekeeper 28 was in		**exposure to the hallway.** · **Dignity cover has been placed at room entrance for staff to utilization upon entering room and noting resident exposed.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: · **All residents refusing to wear clothing or often disrobes have the potential to be affected.** · **Audit completed by Social Service to identify residents care planned for refusing clothing or disrobing completed on 7/1/21.** · **Any resident identified to refuse clothing or disrobing will have room/bed location evaluation per IDT, implementing privacy curtain and dignity cover available upon room entry, and care plan updated to reflect.** · **In-service all staff by 7/2/21 per DNS/Designee on Resident Rights Policy, privacy curtain utilization and dignity cover.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: · **In-service all staff by 7/2/21 per DNS/Designee on**	

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	the resident's room, she leaned over the resident and was talking and laughing with resident while the resident was lying in bed with just a shirt on, she was naked from the waist down and exposed her buttocks and peri-area to the hallway. The Housekeeper cleaned the resident's room with the door open as the resident laid in naked in bed from the waist down. Housekeeper 28 indicated they were use to the resident being naked and they closed her door all the time. The resident's clinical record was reviewed, on 6/16/21 at 9:31 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia in other diseases classified elsewhere with behavioral disturbance, paranoid schizophrenia, anxiety disorder, violent behavior, schizophrenia, need for assistance with personal care and cognitive communication deficit. She had a 6/10/20 problem care plan that indicated the resident often refused to wear clothing, often disrobed, she had a cognitive deficit and was unaware of behavior appropriateness. Her goal was that her preferences would be honored. A 6/10/20 approach indicated to encourage her to cover herself if out in the hallway, if refused, redirect the resident to her room and pull the privacy curtain. A 3/2/21 approach indicated the resident often refused to wear clothing, often disrobed. A 6/14/21 approach indicated to provide privacy curtain and encourage resident to use it. On 6/17/21 at 1:57 p.m., the DON indicated they did not have a policy for dignity. 3.1-3(t)		**Resident Rights Policy, privacy curtain utilization and dignity cover.** · **Charge Nurses will utilize New and Worsening Behavior Event to identify any residents with refusing to wear clothing or disrobing.** · **IDT will review New and Worsening Behavior Events daily in Clinical Meeting and complete an IDT Behavior Review and implement interventions to ensure resident dignity.** · **Care plan will be completed to reflect behavior of refusing clothing and disrobing with interventions added to the resident profile.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: · **On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.** · **CQI tool titled Resident Care Rounds will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved.** · **If Threshold of 90% is not met, an action plan will be**	

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			developed to ensure compliance.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or			

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	discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the			

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	protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to provide notification of transfers to the Long Term Care Ombudsman for 1 of 3 residents reviewed for hospitalization (Resident 38). Findings include: Resident 38's clinical record was reviewed on 6/15/21 at 9:27 a.m. He was transferred and admitted to the hospital on 4/8/21, due to a change in his condition and 5/27/21, due to his biliary tube came out of the insertion site due to the resident had rolled out of bed. The Ombudsman was not notified of either transfer to the hospital.	F 0623	**F 623 Notice Requirements Before Transfer/Discharge** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · **The Social Services Director has notified the Ombudsman of all facility-initiated discharges, including residents who are discharged to ER and returned**. How other residents having the	07/12/2021

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	During an interview with the Nurse Consultant, on 6/16/21 at 3:42 p.m., she indicated the previous Administrator's last day of employment, she thought, was 5/19/21 and he normally sent the Ombudsman's notifications. May transfers were sent to the Ombudsman on 6/16/21. On 6/17/21 at 11:22 a.m., the Nurse Consultant indicated they did not include the residents that had hospitalizations on the notifications to the Ombudsman. A 2/20 revised policy, titled "Facility Initiated Discharge," provided by the DON, on 6/17/21 at 1:57 p.m., indicated the following: "...Procedure...3. The resident will be issued a Notice of Transfer or Discharge consistent with the Indiana State Department of Health form. The form will be delivered to the resident and/or representative as well as the State and Local Ombudsman (via email or fax, at the same time a delivery to the resident)...."		potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · **All residents have the potential to be affected.** · **Social Service Director in-service by 7/2/21 per Regional Social Service Consultant on LTC Ombudsman notification on facility-initiated transfers.** · **Social Services will notify the Long Term Care Ombudsman of facility initiated transfers monthly.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · **Social Service Director in-service by 7/2/21 per Regional Social Service Consultant on LTC Ombudsman notification on facility-initiated transfers.** · **Social Service Director is involved in all transfers or discharges.** · **Social Services will notify the Long Term Care Ombudsman of facility initiated transfers monthly.** · **Reason for resident transfer will be located in resident medical record.** · **IDT will review LTC Ombudsman notification of facility initiated transfers to ensure timely notification.**	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · **On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.** · **CQI tool titled Ombudsman Notification will be completed monthly x 6 months, and quarterly there after until compliance is achieved.** · **If Threshold of 90% is not met, an action plan will be developed to ensure compliance.**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent falls for 2 of 6 residents reviewed for falls (Resident 11 and Resident 26).	F 0689	**F 689 Free of Accident Hazards/Supervision/Devices** What corrective action(s) will be accomplished for those residents	07/12/2021

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	Findings include: 1. On 6/14/21 at 3:23 p.m., Resident 11 was lying in bed, his bed was waist high, bed bolsters and floor mats were beside the bed. Resident 11's clinical record was reviewed on 6/15/21 at 10:14 a.m. Diagnoses included, but were not limited to, vascular dementia with and without behavioral disturbance, anxiety disorder, cognitive communication deficit, muscle weakness, unspecified fall, need for assistance with personal care and initial encounter (history of) note: fall at home. His orders included, but were not limited to, divalproex (anticonvulsant) 125 mg (milligram) three times daily, Fentanyl (narcotic pain reliever) patch 12 mcg/hr (microgram/hour) every three days, gabapentin (treat nerve pain) 300 mg daily, hydrocodone-acetaminophen (narcotic pain reliever)5-325 mg three times daily, metoprolol tartrate (treat high blood pressure) 50 mg twice daily, blue mat at bedside check positioning every shift and bolsters on bed, verify placement every shift twice daily. He had a 11/9/15 care plan that indicated he was at risk for fall due to generalized weakness, history of falls, age greater than 80, incontinence, confusion, diagnosis of diabetes, muscle weakness, dementia with behavioral disturbance, hypertension, lack of understanding of one's physical and cognitive limitations, high risk medication use, impulsive, late effect CVA (cerebrovascular accident). His goal was he would be free from fall related injury. His approaches included, but were not limited to, personal items in reach, call light in reach, therapy screen, non skid footwear, touch call light, offer and encourage		found to have been affected by the deficient practice; · **Resident 11 and 26 have increased care rounds to hourly in an effort to prevent falls.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · **All residents with repeat falls have the potential to be affected.** · **Audit to be completed by 7/1/21 per DNS/Designee to identify residents with repeat falls in the past 30 days.** · **DNS/Designee to review residents identified via audit to ensure adequate supervision in place.** · **In-service Nursing Staff to be complete by 7/2/21 per DNS/Designee on Fall Prevention Program.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · **In-service Nursing Staff to be complete by 7/2/21 per DNS/Designee on Fall Prevention Program.** · **Charge Nurse will complete a Fall Event on all residents with a change in plains.** · **IDT will review all Fall**	

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	activity of choice prior to afternoon meal and mat at bedside. A 11/14/20 significant change MDS (Minimum Data Set), indicated the resident was rarely/never understood. He required extensive assistance of two staff member for bed mobility, transfers and toilet use. He required extensive assistance for personal hygiene and dressing. He was always incontinent of bowel and bladder. He had a fall in the last two to six months prior to admission. A fall risk assessment, dated 11/8/20, indicated the resident was a moderate risk for falls. The resident's fall nurses notes and care plan approaches indicated the following: On 11/25/20 at 5:55 p.m., the writer went to check the resident's blood sugar and the resident was lying on the floor on his right side. He was lying on his over bed table. He was assisted back to bed via hoyer (mechanical lift) lift and two staff members. He had a skin tear to his left forearm and abrasion to his mid chest. Areas had a small amount of bloody drainage. The care plan approach, added 12/2/20, was bedside table out of the way while resident was sleeping. On 12/2/20 at 12:00 p.m., the writer heard a noise come from resident's room, he was observed lying on his left side on the floor mat next to the bed. He had an abrasion to his left forehead. He was assisted back into bed via two staff members. He was incontinent and care was provided. Mattress was to be replaced as immediate intervention. On 12/2/20 at 2:13 p.m., IDT (Interdisplinary Team)		**Events daily in Clinical Meeting, determine root cause of fall and implement increase supervision if indicated for repeat falls.** · **Resident care plan will be updated with new interventions and added to the resident profile.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · **On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.** · **CQI tool titled Supervision will be completed weekly x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved.** · **If Threshold of 90% is not met, an action plan will be developed to ensure compliance.**	

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	reviewed the fall that occurred on 11/25/20 at 5:30 p.m. He was noted on floor by bed, laying on his right side. He was in gown and was continent. Skin tear was noted to his left forearm and an abrasion to mid chest. Contributing factors to fall were the resident rested on low air loss mattress to promote skin integrity, often this will facilitate slide out, would replace low air loss mattress and ensure bed bolsters to provide bed boundaries. Would ensure the bedside table was away from the bed while resident was sleeping. The care plan approach, added on 12/3/20, was to check for incontinence every one and a half hours and ensure placement in center of bed to avoid slide out . A fall risk assessment, dated 12/14/20, indicated the resident was a high risk for falls. A 12/17/20 significant change MDS (Minimum Data Set), indicated the resident was rarely/never understood. He required extensive assistance with two staff member for bed mobility. He required total assistance of two staff members for transfers and dressing. He required total assistance of one staff member for personal hygiene. He had a life expectancy prognosis of less than six months. He was always incontinent of bowel and bladder. On 1/6/21 at 1:29 p.m., the resident utilized a low air loss mattress on bed, mattress had built in bolsters to aide bed boundary awareness, resident required bed bolsters for safety due to poor safety awareness and risk of falls. Bed bolsters would be discontinued on bed for clarification as not to attach bolsters to air mattress. On 2/20/21 at 4:32 a.m., the nurse entered the resident's room to administer his pills and found			

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	resident had rolled himself out of bed, CNA helped to get resident off of the floor via hoyer lift. Skin tear on left arm had reopened and appeared to be some slight bruising on his left hip, bolsters were added to his bed at that time. On 2/21/21 at 2:10 p.m., staff noted the resident was lying on the floor on top of mat with blankets around his body, facing the doorway. Bed in the lowest position and bed bolsters were in place. Three staff assisted him back to bed without difficulty. The hospice nurse was updated and also informed staff had noted him to be more restlessness. Hospice nurse coming to facility and would review his medications. On 2/22/21 at 10:45 a.m., IDT reviewed fall from bed on 2/20/21 at approximately 4:00 a.m. He was noted lying on the mat at bedside, with small skin tear to his left elbow and a faint bruise to his left hip. Resident was not incontinent. He had poor safety awareness and was very impulsive, potentially resident heard nurse who was passing medication in hall and got too near side of bed sliding out of bed onto floor. Immediate intervention was to place bolsters on bed to aide bed boundary awareness, Resident fell out of bed the following afternoon. Resident was resting in bed following afternoon meal. Staff reported the resident had increased activity and restlessness escalating in frequency. The resident received hospice service for end of life comfort, he had late stage dementia, poor safety awareness and impulsivity. The resident potentially had increased discomfort evidenced by increased restlessness, staff requested hospice medication evaluation, new orders received to increase tramadol (pain reliever) for comfort. The care plan approach, added 2/22/21, was			

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	bolsters on bed, verify placement every shift and comfort medication review. On 3/3/21 at 3:31 a.m., the nurse was approached by CNA, she had found resident on floor beside the bed lying in a large pool of blood. Writer observed resident on floor with blood pooling underneath his head. Bolsters were appropriately attached to the bed and bed in the lowest position. Resident was responsive, but nonsensical in speech. He was transferred to the emergency room by floor staff. The writer requested a bariatric bed for him. On 3/3/21 at 3:31 a.m., POA/spouse was notified of the resident had fallen out of bed, with a head wound, moderate to maximum amount of blood on floor. He was sent to the hospital due to blood amount. Hospice had returned call to the facility and stated she would put an order in for geriatric bed. Hospital notes, dated 3/3/21, indicated the resident had fallen three feet off the bed and hit his head on the floor and had a laceration from hitting head on the floor. On 3/3/21 at 10:17 a.m., IDT reviewed resident's fall out of bed. He had been resting in bed as appropriate for early am hour of sleep. Staff entered room and noted resident was lying on abdomen on the mat at bedside. He was dressed in night clothes with non skid footwear on, bolsters on bed, room clean, floor dry, environment calm and quiet with adequate ambient lighting for hour of sleep. The resident had small laceration to right eyebrow, moderate bleeding, nurse practitioner was notified and resident transferred to emergency room for evaluation and treatment. He returned to the			

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	facility with three sutures to his right brow, xrays/CT (computed tomography) scan negative for fractures. Resident did have history of falls and was at risk for fall due to generalized weakness, history of falls, age greater than 80, incontinence, confusion, diagnosis of diabetes, Muscle weakness, dementia with behavioral disturbance, hypertension, lack of understanding of one's physical and cognitive limitations, high risk medication use, impulsive, late effect CVA. Interventions in place to reduce risk of fall with significant injury include bolsters on bed, comfort medications, incontinence checks every 90 minutes, ensure resting in center of bed to avoid slide out of bed, mat at bedside, offer and encourage activity of choice prior to afternoon meal, non skid footwear, therapy screen, touch call light, call light in reach and personal items in reach. Resident received hospice services for end of life comfort. Staff reported resident with increased anxiety as evidence by restlessness, perpetual motion and movement of extremities, fidgeting and slouching. Hospice was notified and would assess. New interventions initiated included room move near nurse station, wider bed to aide in bed mobility and discontinued gel mattress overlay on bed. The care plan approach, added 3/3/21, was to discontinue gel mattress overlay, room move nearer nurse station and wider bed. During an interview on 6/16/21 at 9:59 a.m., with the DON, with the Nurse Consultant present, indicated he had repetitive movement the last 30 days and he was declining rapidly as his dementia progressed. Care plan approaches after his falls were discussed. On 6/17/21 at 9:56 a.m., CNA 29 indicated the			

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	resident tapped and clapped his hands and he may reach at you when you turn him in his bed, he usually fell asleep before they got his the room picked up after they laid him down, he had mats on both sides of his bed and bolsters on his bed. If the resident was a fall risk it would be on the CNA assignment sheet. His bed was to be in the lowest position, but was unable to go all the way to the floor because the wheels would be unlocked and the bed would roll. 2. A review of the matrix provided by the facility, on 6/13/21 at 4:15 p.m., indicated Resident 26 had a fall with injury. Resident 26's medical record was reviewed on 6/15/21 at 8:30 a.m. Diagnoses included, but were not limited to, Alzheimer's disease unspecified, Wernicke's encephalopathy, violent behavior, repeated falls, anxiety disorder, and violent behavior. Medications included, but were not limited to, Ativan (anxiety) 0.5 milligrams (mg) by mouth twice daily, haloperidol (antipsychotic)1 mg. by mouth daily, haloperidol 3 mg. by mouth at bedtime, and morphine (pain) concentrate solution 0.25 milliliters by mouth as needed every 2 hours. Orders included, but were not limited to, Heart to Heart hospice, hipsters during waking hours for repeated falls, offer rest periods after meal as resident allows, touch call light, blue mat to both sides of bed and observe for anti-anxiety side effects of drowsiness, sedation, ataxia, and dizziness. A 3/31/21, quarterly Minimum Data Set (MDS) assessment, indicated the resident's cognitive status was severely impaired. Her behaviors were continuous inattention and disorganized thinking.			

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	Psychosis involved hallucinations and delusions. She required a two person extensive assist for transfer and toileting with frequent incontinence of bowel and bladder. She required one person assistance with eating, dressing, and personal hygiene. Walking in the room and on/off the unit was not assessed during the MDS assessment. She had a fall risk on admission with 2 or more falls since the last assessment/admission with no injury. Review of a 3/30/21 Johns Hopkins Fall Risk Assessment Tool, indicated the resident was a high fall risk with a score of 23. A current care plan for falls, dated 7/16/20 and last revised 6/7/21, indicated the resident had multiple risk factors for falls related to a diagnosis of dementia, history of falls, altered perception of surrounding, unaware of her own physical limitations, impulsivity, weakness, poor balance, high fall risk medications, limited cognition, and often removed non-skid footwear. Interventions included, but were not limited to, staff assistance during ambulation for safety as accepted, encourage resident to allow staff assist to standing position to aide balance before attempting to walk, offer morning snack between breakfast and lunch, offer and assist resident to sit in chairs as desired and accepted, offer and encourage bed rest after lunch, offer and assist resident to sit on couch as accepted, hipsters on when up as accepted, encourage non-skid socks and/or footwear as accepted, non-skid footwear, and offer and encourage wheelchair for mobility as accepted. A 3/1/21 Nurse's Note indicated the resident had ambulated in the activity area of the Cottage, attempted to sit near another resident, lost her			

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	balance, and fell onto her buttocks on the floor. The fall was witnessed with no injuries and the resident did not hit her head. A 3/4/21 Nurse's Note, indicated the nurse was called to the 2nd floor by a Qualified Medication Aide (QMA) who indicated she heard a loud noise and found the resident sitting on the floor on left side of buttocks. A 3/4/21 Interdisciplinary Team wound note, indicated the resident had a pale purple bruise to the left cheek and left jaw area and skin was intact. A 4/7/21 Nurse's Note, indicated the resident was sitting on couch and stood up, started to walk, and fell during ambulation on right side of body. The fall was witnessed and Resident 26 did not hit her head. Another 4/7/21 Nurse's Note, indicated the resident had a second fall after she attempted to get in bed and was found sitting next to bed on her buttocks with no injuries noted. A 4/15/21 Nurse's Note, indicated Resident 26 had paced around the dining room and tried to sit in a chair and missed the chair and knelt down on the floor. The resident had some redness noted to the left knee but the resident refused assessment and continued to pace. A 4/30/21 Nurse's Note, indicated Resident 26 attempted to stand up from a dining room chair, lost her balance, and fell to the floor on her right hip with no injuries. The new intervention was to attempt to assist the resident to a standing position to ensure she had her balance before ambulation.			

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	A 5/3/21 Nurse's Note, indicated the writer heard a noise, found the resident on the bedroom floor, her feet faced the doorway and her head faced the window. The resident was on her back with blood around her mouth and a laceration noted to the inner upper lip. A skin tear to the left inner elbow was noted. The resident refused ice to lip but accepted a wet cloth. An intervention was implemented for staff to assist resident while walking when accepted. A 5/12/21 Hospice Face to Face Encounter Note, provided by Licensed Practical Nurse (LPN) 33, indicated Resident 26 had a shuffled gait when she walked, she was continued on morphine twice daily for pain management, and has had a fall during the recertification period and faint bruising was noted to her face. A 5/13/21 Hospice Progress Note, provided by Licensed Practical Nurse (LPN) 33, indicated the resident continued with confusion and agitation with 7 falls in the past 3 months and required increased agitation medications such as Haldol. A 6/5/21 Nurse's Note, indicated the resident wandered into another resident's room and was found by staff sitting on her buttocks. A small reddened area was noted to the back of her left arm with no skin tears or open areas found. Neurological checks were initiated. A 6/7/21 Nurse's Note, indicated the resident ambulated with a shuffling unsteady gait, marched in place, and ambulated rapidly in halls with head slightly leaned forward. During an observation, on 6/14/21 at 9:00 a.m., Resident 26 was resting on the sofa in the dining room with a non-skid sock noted on the right foot			

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	and a bare left foot. During an observation, on 6/15/21 at 8:22 a.m., the resident stood up from the dining room table and ambulated with an unsteady shuffling gait 15 ft from the table without staff assistance. On 6/15/21 at 8:25 a.m., Resident 26 sat on the edge of the couch in the Cottage Unit. She stood up in an impulsive manner without assistance, shuffled her feet, sat down on the couch in an abrupt manner, and leaned over onto her right side on the couch and placed her legs up on the couch with her head on the couch arm rest. During an observation, on 6/15/21 at 8:33 a.m., the resident stood up from the couch in the Cottage unit dining room, walked unassisted with a shuffling gait, and leaned forward during swift ambulation. She walked with a shuffled gait 25 feet to the first resident room from the nurse's station and headed toward another residents bed. Resident 26's room was located at the end of the hallway farthest from the nurse's station on the Cottage unit. A wheelchair was not offered or encouraged. On 6/15/21 at 2:19 p.m., Resident 26 laid on the couch in the Cottage Unit dining area. The resident was noted to have a non-skid sock on her right foot and a bare left foot. The missing sock was not observed in the Cottage dining room nor in the possession of the resident. During an interview, on 6/15/21 at 2:23 p.m., Certified Nurse's Aide (CNA) 37 indicated she worked on the Cottage Unit and was familiar with the residents. She indicated the CNA's reference the CNA task list on the computer for any ADL assistance needs or any other special requirement,			

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	but they also had a paper copy at the Nurse's Station. She indicated Resident 26 required one to two person assistance for ambulation and depended if she exhibited any behaviors. CNA 37 indicated Resident 26 is a fall risk with an unsteady gait. Review of a current second floor resident care sheet, provided by the Memory Care Support Specialist on 06/15/21 at 2:35 p.m., indicated Resident 26 was up ad lib with no mention of staff assistance. During an interview, on 6/16/21 at 11:35 a.m., LPN 33 indicated Resident 26 had a shuffling gait and has had several falls. LPN 33 indicated Resident 26 should have assistance to walk. During an interview, on 6/16/21 at 3:47 p.m., LPN 33 indicated Resident 26 did not have any specific frequency checks in place as a result of the frequent falls. On 6/17/21 at 10:13 a.m., LPN 35 indicated Resident 26's gait was stable with assistance but she often walked without assistance. During an observation, on 6/17/21 at 10:28 a.m., Resident 26 stood up unassisted from the couch in the Cottage dining room with a shuffling gait, leaned forward and ambulated down the hall greater than half the distance of the hallway, turned around, then shuffled back to the couch in the dining room with no staff assistance or redirection. The resident lacked non-skid footwear and walked in her bare feet. A wheelchair and non-skid footwear was not offered. During another observation, on 6/17/21 at 10:36			

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	a.m., Resident 26 remained without non-skid footwear, stood up from the couch, ambulated down the hall to room 214 with a shuffling unsteady gait as she leaned forward in a brisk manner. She turned around in her bare feet and walked back to the dining room unassisted and sat at a dining room table. The resident was not redirected or assisted during the observation. A wheelchair was not offered or encouraged during the observation. A current policy, titled "Fall Management Program," provided by RN 31 on 6/16/21 at 4:00 p.m., indicated the following: "POLICY...It is the policy of American Senior Communities to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls...." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0732 SS=B Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.			

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	§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to ensure nurse staffing data was posted daily and visible for residents and visitors. Findings include: During an interview at the time of observation, on 6/16/21 at 11:51 a.m., along with Registered Nurse (RN) 31, the nurse staffing data was found behind the desk by the facility main entrance door and was dated 6/10/21. RN 31 indicated the nurse staffing data was last posted on 6/10/21 and had not been posted for 5 days. During an interview, on 6/17/32 at 10:02 a.m., the Administrator indicated nurse staffing data should be posted daily in the facility.	F 0732	**F 732 Posted Nurse Staffing Information** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · **Nurse staffing was updated and posted immediately.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · **All resident have the potential to be affected.**	07/12/2021

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	A current policy, titled "Posted Nurse Staffing Data and Retention Requirements," provided by RN 31 on 6/17/21 at 11:02 a.m., indicated the following: "...Policy: It is the policy of American Senior Communities to make staffing information readily available in a readable format and publicly posted to residents and visitors at any given time....Procedure: 1. The facility must post the following information at the beginning of each shift. a. The facility name b. The current date c. Resident census d. The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered nurses ii. Licensed practical nurses iii. Certified nurse aides...11. The nurse staffing data must be posted in a prominent place readily accessible to residents and visitors...."		· **Nurse Scheduler in-service by the DNS on posting Nurse Staffing Data daily by 7/2/21.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · **Nurse Scheduler in-service by the DNS on posting Nurse Staffing Data daily by 7/2/21.** · **Daily observation that Nurse Staffing Data is posted will be completed by Payroll Coordinator.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · **On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.** · **CQI tool titled Staffing Data will be completed daily x 4 weeks, monthly x 6 months, and quarterly there after until compliance is achieved.** · **If Threshold of 90% is not met, an action plan will be developed to ensure compliance.**	
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:			

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	155162	A. BUILDING 00 B. WING	06/17/2021

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	(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	A. Based on observation, interview and record review, the facility failed to ensure infection prevention strategies were utilized for urinary catheter maintenance for 1 of 3 residents reviewed (Resident 19) for infection prevention related to a urinary catheter and failed to ensure infection prevention strategies were utilized during a medication administration for 1 of 2 residents reviewed for infection prevention related to ophthalmic medication administration (Resident	F 0880	**F 880 Infection Prevention and Control** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · **Resident 19 catheter tubing was immediately corrected.**	07/12/2021

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	35). Findings include: A. During an observation, on 6/14/21 at 3:33 p.m., Resident 19 was resting in bed with the head of his bed at 40 degrees, blankets covered the resident, and the bed framework was exposed. The wheelchair was noted at the foot of the bed. Resident 19's catheter was not hanging anywhere below the level of the bladder on the bed framework. During an observation, on 6/15/21 at 8:41 a.m., Resident 19 sat in his wheelchair in the Cottage Unit dining room as he ate his breakfast. His urinary catheter tubing and collection bag hung below the wheelchair and touched the floor. On 6/15/21 at 9:03 a.m., Resident 19 sat in the Cottage Unit dining room in his wheelchair with the urinary catheter collection bag and tubing against the floor. On 6/15/21 at 10:46 a.m., Resident 19 sat in the recliner in the Cottage Unit dining room. His wheelchair was adjacent to the recliner and the urinary catheter collection bag hung below the wheelchair and against the floor. During an observation, on 6/15/21 at 2:40 p.m., Resident 19 was resting in bed with his bed in low position. The urinary catheter collection bag was not attached to the bed and laid on the floor next to the catheter tubing. During an observation at the time of interview, on 6/15/21 at 2:44 p.m., Licensed Practical Nurse (LPN) 37 indicated Resident 19's urinary catheter		· **Resident 19 has had no urinary tract infections in past 6 months.** · **Resident 35 has had no eye infections in past 6 months.** · **LPN 13 was educated on infection control practices when instilling eye drops.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · **All residents with catheters and residents that receive eye drops have the potential to be affected.** · **Audit completed by 7/1/21 per DNS/Designee to identify all residents with catheters and residents receiving eye drops.** · **Residents identified will be reviewed by Infection Preventionist to ensure no recent infections.** · **In service all Nursing staff by 7/2/21 per IDT/IP/Designee on Infection Control Practices specific to catheters and instilling eye drops.** · **Daily observational rounds to ensure appropriate catheter placement and instilling eye drop per procedure x4 weeks or until compliance is met per IDT/IP/Designee.** · **Skills validation for Instilling Eye Drops to be**	

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	collection bag and tubing laid on the floor and was a risk for infection. She indicated the resident had a leg bag but it was not appropriate when the resident rested in bed. She entered the resident's room, picked up the urinary catheter collection bag and tubing off of the floor, and attached it to the bed framework. LPN 37 indicated it was not appropriate for the urinary catheter collection bag or tubing to touch the floor when the resident was in the wheelchair or the bed. Review of Resident 19's clinical record was completed on 6/15/21 at 4:00 p.m. Diagnoses included, but were not limited to, benign prostatic hyperplasia with lower urinary tract symptoms and other obstructive and reflux uropathy. Orders included, but were not limited to, Foley catheter (urinary catheter) size 14 French. 10 milliliter bulb, and tamsulosin (prostate) 0.4 milligram by mouth once daily. A 3/24/21, quarterly Minimum Data Set (MDS) assessment, indicated the resident's cognitive status was severely impaired, he had an indwelling urinary catheter, and required extensive two person assistance for toileting . A current care plan for indwelling catheter, dated 6/15/20 and last revised 3/31/21, indicated the resident required an indwelling catheter due to enlarged prostate and obstructive uropathy. Interventions included but were not limited to: avoid obstructions in the drainage, the tubing or any part of the drainage system was not allowed to touch the floor, Foley catheter; uses leg bag, catheter to be changed per provider order, Foley catheter size: 14 French. 10 milliliter bulb per order , and bag must be positioned below the level of the bladder.		**complete with all nurses x 1 to demonstrate competency per IDT/IP/Designee.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · **In service all Nursing staff by 7/2/21 per IDT/IP/Designee on Infection Control Practices specific to catheters and instilling eye drops.** · **Daily observational rounds to ensure appropriate catheter placement and instilling eye drop per procedure x4 weeks or until compliance is met per IDT/IP/Designee.** · **Skills validation for Instilling Eye Drops will be completed for all new hired staff to demonstrate competency, per IDT/IP/Designee.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · **On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.** · **CQI tool titled Instilling Eye Drops and Catheter tubing will be completed weekly x 6 weeks, monthly x 6 months,**	

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	During an interview, on 6/16/21 at 9:08 a.m., the Director of Nursing (DON) indicated it was not appropriate for a urinary catheter drainage bag and tubing to touch the floor. A request to the DON was made for a catheter infection prevention policy. A policy was not provided. During an interview, on 6/16/21 at 9:42 a.m., RN 31 indicated the facility did not have a catheter policy related to catheter infection prevention. She indicated, " It is a given that catheter bags and tubing should not be touching the floor." RN 31 provided a copy of a facility quality assurance performance checklist for urinary catheters. Review of a blank Quality Assurance Tool for catheters, labeled "Quality Assurance Tool Quality Indicator: Catheter," provided by RN 31 on 6/16/21 at 9:42 a.m., indicated the following: "...Catheter bags remain covered and maintained below the level of the bladder. Catheter tubing is not touching or dragging on the floor..." A Center for Disease Control and Prevention (CDC) document, titled "Guidelines for Prevention of Catheter-Associated Urinary Tract Infections (2009)," obtained from the CDC website on 6/18/21 at 7:15 a.m., indicated the following: "...III. Proper Techniques for Urinary Catheter Maintenance...III.B.2. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor..."B. During a medication administration observation, on 6/16/21 at 8:00 a.m., LPN 13 prepared Resident 35's medications, locked the medication cart, and entered the resident's room. He provided her oral medications to her, then immediately instilled her eye drops into both eyes by pulling down her lower lids with his left hand while holding a tissue. He did not		**and quarterly there after until compliance is achieved.** **· If Threshold of 90% is not met, an action plan will be developed to ensure compliance.**	

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	wear gloves, nor perform hand hygiene during the observation until after he instilled the eye drops. During an interview, on 6/16/21 at 11:59 a.m., LPN 13 indicated he should have worn gloves to instill the eye drops. Review of a current facility policy, titled "Instilling Eye Drop(s)...," dated 1/2013 and provided by the Nurse Consultant on 6/17/21 at 11:25 a.m., indicated the following: "...Perform hand hygiene...Obtain correct medication...Lock medication cart...Instill...Recap bottle...Perform hand hygiene...." 3.1-18(b)(1) 3.1-18(l) 3.1-41(a)(2)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure direct care staff had active certifications prior to providing resident care (CNA 17). Findings include: During a review of employee records, on 6/14/21 at 12:23 p.m., the following was observed:	F 9999	**F 9999 Personnel** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · **Certification for CNA 17 has been updated.** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · **All residents that received care from CNA 17 during 5/23/21 through 6/11/21 have the potential to be affected.**	07/12/2021

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	CNA 17's Indiana Nurse Aide certification had expired on 5/23/21. Review of a facility staffing schedule indicated she had been assigned to work 16 shifts from 5/23/21 through 6/11/21. During an interview, on 6/17/21 at 11:03 a.m., the Nurse Consultant indicated CNA 17 had worked the hours indicated on the schedule. During an interview, on 6/17/21 at 11:22 a.m., the Nurse Consultant indicated the CNA's expired certification had been missed during the facility's regular review of licensures and certifications.		· **Grievances reviewed 5/23/21 through 6/11/21 per Social Service with no concerns identified related to resident care.** · **License Binder to be audited by 7/1/21 per DNS/Designee to ensure all direct staff have active certification.** What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · **License Binder will be reviewed monthly by Payroll Coordinator to verify that all direct care staff have accurate certification.** · **Payroll Coordinator will verify upon hire active certification.** How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; · **On going compliance with this corrective action will be monitored via facility QAPI program, with meetings being held monthly, and is overseen by the Executive Director.** · **CQI tool titled Staff Licensure will be completed monthly x 6 months, and quarterly there after until compliance is achieved.** · **If Threshold of 90% is not met, an action plan will be**	

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			developed to ensure compliance.	