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	155582	A. BUILDING 00 B. WING	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE	300 N WASHINGTON ST WAKARUSA, IN 46573

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00450476, IN00450474, IN00449957, IN00449158, IN00448896, IN00448468, IN00448438, IN00448271, IN00447703, IN00447260, IN00447101 and IN00446753. This visit resulted in Immediate Jeopardy. Complaint IN00450476 - Federal/State deficiencies related to the allegations are cited at F812 and F677. Complaint IN00450474 - Federal/State deficiencies related to the allegations are cited at F812. Complaint IN00449957 - No deficiencies related to the allegations are cited. Complaint IN00449158 - Federal/State deficiencies related to the allegations are cited at F812. Complaint IN00448896 - Federal/State deficiencies related to the allegations are cited at F812. Complaint IN00448468 - No deficiencies related to the allegations are cited. Complaint IN00448438 - Federal/State deficiencies related to the allegations are cited at F622, F623, F624 and F693. Complaint IN00448271 - No deficiencies related to the allegations are cited. Complaint IN00447703 - No deficiencies related to the allegations are cited. Complaint IN00447260 - No deficiencies related to	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is 01/28/25. The facility is respectfully requesting paper compliance for all deficiencies in this POC.	

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

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

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	the allegations are cited. Complaint IN00447101 - No deficiencies related to the allegations are cited. Complaint IN00446753 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: January 2, 3, 5, 6, 7 & 8, 2025 Facility number: 000521 Provider number: 155582 AIM number: 100266980 Census Bed Type: SNF/NF: 86 Total: 86 Census Payor Type: Medicare: 2 Medicaid: 59 Other: 25 Total: 86 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/14/25.			
F 0622 SS=J Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements Based on record review and interview, the facility failed to ensure a notice of discharge was provided in writing, discharge planning was completed, and a resident's discharge was safe with continuity of care ensured for 1 of 3 residents reviewed for discharge. (Resident E) This deficient	F 0622	The Administrator/Designee notified Resident E on 1/23/2025 of Resident E's rights and offered to re-admit Resident E to the facility and offered to have the residents family member on the	01/28/2025

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	practice resulted in an unsafe discharge when the resident was transferred to a hospital waiting area without admission arrangements and no way to obtain nutrition through enteral feedings. The resident voiced feeling of hopelessness and felt others wanted him to die. The immediate jeopardy began on 12/24/24 when the facility discharged Resident E to a hospital waiting area. The Administrator and Regional Administrator were notified of the immediate jeopardy at 3:58 P.M. on 1/6/25. The immediate jeopardy was removed on 1/7/25, but the noncompliance remained at the lower scope and severity level of isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy Finding includes: The clinical record for Resident E was reviewed on 1/5/25 at 2:00 P.M. Resident E was admitted to the facility on 11/23/24 from an acute care facility following surgical repair of necrotizing pancreatitis. The resident's diagnoses included, but were not limited to, status post (s/p) perforation of the esophagus, acute pancreatitis with uninfected necrosis, gastroesophageal reflux disease with esophagitis, fistula of the stomach and duodenum, and gastrostomy placement. The resident had a gastrostomy/jejunostomy tube (a GJ tube - combination of a tube placed in the stomach and a tube placed in the jejunum that is secured with a balloon or plastic bumper in the stomach and a plastic disc around the outside of the body.) The resident was admitted with physician orders for enteral tube feedings and nothing by mouth (NPO) except diet soda and medications. The acute care transfer documentation indicated the plan was for the		call, resident E declined having sister on the phone call. The Administrator/Designee also notified Resident E's responsible party and informed the sisters of the resident's intent to return to the facility on 1/23/2025. Resident E verbalized understanding of the information communicated. The Administrator left a message for the Ombudsman on 1/23/2025. The Administrator/Designee arranged for re-admission on 1/24/2025. Residents E's previous room was available and Resident E accepted room number 30-1. The Administrator and Interdisciplinary team including the Administrator, Director of Nursing, Nurse Practitioner, Nurse, MDS and CNA met with Resident E and care plans were revised on 1/24/2025. Facility offered to include resident representatives in care plan meeting including family members and Ombudsman. Resident E declined these representatives involvement in meeting. The Administrator/Designee in-serviced the staff on the plan of care for Resident E on or before 1/27/25. Courtney and Associates completed an in-service on or before 1/27/25 with Social Services, Administrator, and nursing staff on transfer and discharge requirements. Staff members completed a Post Test	

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	resident to receive nutrition via an enteral tube feeding in the extended care facility until a gastrointestinal surgical consult was completed in four weeks. The resident was to have a Computerized Tomography (CT) scan performed in two weeks. The surgical note indicated in January, the resident's condition was to be reevaluated, a cholecystectomy performed, surgical repair of the resident's intestinal system performed and the G/J tube removed. The Admission Minimum Data Set (MDS) assessment, completed on 11/30/24, indicated the resident was admitted for short stay rehabilitation from an acute care facility. The assessment indicated the resident was cognitively intact, had not displayed any mood issues or behaviors during the assessment period, was dependent on staff for feeding due to requiring enteral feedings, utilized a walker and/or wheelchair for mobility needs, required moderate staff assistance for lower body dressing, applying footwear, and bathing needs, received physical and occupational therapy and did not require an active discharge plan. An Admission Care plan meeting note, completed on 11/29/24 at 11:01 A.M., indicated the resident attended the meeting and both sisters had participated via telephone. The resident was working with therapy to evaluate his ability to perform his own Activities of Daily Living (ADL) needs and the discharge goal was for the resident to discharge to an assisted living group home setting. There were no recommendations documented as a result of the care plan meeting. There was no further follow-up with discharge planning. A Discharge care plan for Resident E, dated		to demonstrate understanding. Additionally, any staff members that fail to comply with the points of this in-service will be further educated and/or disciplined as indicated. All residents that discharge from the facility have the potential to be affected by the alleged deficient practice. A 30 day look back of all facility discharges was completed by SSD on or before 1/6/25 to ensure adequate notice of discharge and discharge planning and to ensure that the resident's no longer required the facility's nursing care and able to meet medical needs upon discharge. On 1/6/25 Licensed Nurses and Interdisciplinary Team were in-serviced on the following: 1.Transfer/ Discharge Procedure 1.Unplanned discharges 1.Providing education to family or resident on medical needs upon discharge. Staff knowledge of the in-servicing will be measured by a POST Test requiring 100% accuracy of the answers to "pass." Any licensed nurse or Interdisciplinary Team member that is unable to complete education due to LOA on or before 1/6/25, will be required to complete education and post-test prior to returning to work. Any newly hired licensed nurses	

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	12/16/24 with a target date of 2/28/25, indicated the resident's goal was to discharge from the facility after a short-term stay. The focus indicated the resident planned to return home with a family member. The goals were for the resident to actively participate in therapy, as shown by his attendance and cooperation, and to have a safe discharge home. The only intervention listed for the plan was to assist the resident and family with discharge planning. A care plan, dated as revised on 12/5/24, indicated the resident was at risk for nutritional status deficit related to nothing by mouth (NPO) status and tube feeding for nutritional support. Interventions included, but were not limited to, tube feedings and flushes per the physician orders, monitor weights and laboratory values. During an interview, on 1/7/25 at 3:00 P.M., Employee 23 indicated the resident had been discharged from therapy services on 12/6/24, and the resident had remained at the facility. There were no nursing and/or social service progress notes regarding discharge needs until a Social Service Note, dated 12/23/24 at 2:35 P.M., indicated the Social Service Director (SSD) spoke with the resident and, via a phone call with one of the resident's sisters, informed the resident and his sister that the facility had nothing to "skill" the resident on, so he needed to leave because his insurance would not pay his bill. The resident informed the SSD he would be living on the streets. His sister was asked to come to the facility the following day for some "training and the discharge." The resident's sister indicated she was going to call the "State" and bring them with her.		or Interdisciplinary Team members will be educated on hire/ return and competence validated during orientation. Any staff who fail to comply with the points of the in-servicing will be further educated and/or progressively disciplined as indicated. An Ad-Hoc QAPI meeting was held by the Administrator, Interdisciplinary Team and Medical Director on 1/6/25 to review and approve the Plan of Removal and Allegation of Compliance. The SSD/ Designee will complete the Audit Tools that was created on 1/6/25 to include monitoring of discharges to ensure that the facility provided adequate notice and discharge planning and to ensure that the resident no longer required the facility's nursing care daily 2x's weeks, and monthly x's 5 months or until substantial compliance is achieved. The QAPI Committee will review the audit tools on a monthly basis and will determine compliance. Any concerns will have been addressed. If indicated, additional Action Plans will be recommended and/ or written by the QAPI Committee. All action plans will be monitored weekly by the Administrator to ensure substantial compliance.	

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	Social Service Notes, dated 12/24/24 at 10:17 A.M. and 12/24/2024 at 4:21 P.M., indicated the SSD attempted to leave messages for both sisters regarding the resident's discharge time. A Social Service Note, dated 12/24/24 at 2:25 P.M., indicated one of the resident's sisters had left a phone message that the resident was to be transported to the local hospital because she refused to "take him in." A follow-up entry from the SSD, dated 12/24/24 at 2:19 P.M., indicated the resident wanted to go to the local hospital to speak with his doctors and then he planned to get a bus ticket out of the state to go to his sister's. There was no documentation in the record that indicated the resident had any prior communication about wanting to discharge until he was informed he would have to leave. There was no documentation in the record to indicate the SSD or any other staff attempted to provide any written notice of discharge, services for discharge planning, or services to ensure continuity of care to the resident or family. The physician's orders for Resident E lacked an order to discharge the resident from the facility. During an interview on 1/6/25 at 3:36 P.M., the Medical Director indicated he had not been notified nor had any record of ordering a discharge for Resident E. A Nursing Progress Note, dated 12/24/24 at 4:12 P.M., indicated the resident was transported by the facility transporter to the local hospital as requested by the resident. However, a Nursing Progress Note, dated 12/24/24 at 4:14 P.M., indicated the resident was "discharged to home."			

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	A Resident Discharge Summary, completed on 12/24/24 by the Director of Nursing (DON), indicated Resident E was discharged to Home/Community accompanied by his family - "sister/family to drive him home." The resident was given discharge instructions and discharged with all of his personal belongings but declined education on his gastronomy tube. The resident was quoted as stating "I am going to be dropped off at [name of local hospital] and they will take it [gastronomy tube] out for me." No community resources were listed and 'None Needed" was marked. Additional comments on the form were as follows, "Resident is discharging because we can no longer skill his services. He has no forwarding address so home health cannot be scheduled." A Nursing Progress Note, dated 12/24/24 at 6:10 P.M., indicated the facility received a phone call from a nearby community police department. They informed the facility that Resident E was at the local hospital and claimed he had been "kicked out" of the long-term care facility and they had "dumped" him off at the hospital. The facility nurse documented she had corrected the officer and informed him the resident was discharged from the facility because his insurance had "cut him off" and his sister had "refused to come get him." She indicated the resident had requested to go to the local hospital because of his feeding tube. A (Name of Hospital) admission note indicated the resident arrived at the hospital on 12/24/24 at 4:38 P.M. for feeding tube issue. The Emergency Room (ER) note indicated the resident presented with complaints, "...they discharged me from the [name of facility] rehab [rehabilitation] today and I have no place to go...I have this feeding tube in place and I am forced to be outside tonight, it			

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	could freeze and freeze my internal organs...I need to be readmitted..." The note indicated the resident was evaluated and, "...differential diagnostic consideration include social situation of him being homeless tonight on Christmas Eve. Unfortunately, my care coordinators have left for the day as it is after 5 p.m...." The case was discussed with the house supervisor and there was no medical need for an inpatient stay. He was safe to discharge. A (Name of Hospital) ER note, dated 12/25/24, indicated the resident presented to the ER with his sister. The resident had a history of complex medical history necrotizing pancreatitis with J tube feedings. He complained of feeling depressed due to his current situation, as he was unhoused. He was discharged from a nursing home two days ago. The sister indicated she had been calling everyone to try to get help. The resident indicated he was tube dependent and had not had any feedings for the past two days and was discharged without any equipment. The note indicated, "...Patient is feeling hopeless because he feels like everyone in the state of Indiana wants him to crawl in a ditch and die...Patient is feeling depressed and hopeless like he would be better off dead...I do not feel comfortable discharging him home because he has no way to get nutrition...." The (facility name) was contacted and indicated the resident was transported to the ER yesterday because he had no home, and family would not pick him up. He was not prescribed any feedings and there were no definite arrangements that staff were aware of and they would fax the discharge summary. A (Name of Hospital) Discharge Note indicated the resident arrived at the hospital on 12/25/24 at 4:27 P.M., after making suicidal statements. The			

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	documentation indicated the resident had been in the acute care facility for a prolonged stay, was discharged to the long-term care facility with tube feedings to be continued, and a GI (gastro-intestinal) physician follow-up to have occurred in January 2025. The note indicated the resident was discharged from the long-term care facility but was homeless with nothing set up for his tube feedings. The note indicated he was unable to go to any of the homeless shelters in the area due to the tube feeding, and so he had presented to the emergency department feeling "hopeless." The emergency room note indicated the resident was not able to take in nutrition orally and had complex social issues. The resident was evaluated in the emergency room by psychiatry due to the suicidal comments he had made and deemed not actively suicidal, but just "feeling hopeless" due to his situation. The resident was admitted to the acute care facility with diagnoses including, but not limited to, cellulitis of the lower extremities with antibiotic therapy ordered and continued need for jejunal nocturnal (night) tube feedings for nutritional needs. On admission, he also had bilateral lower extremity deep vein thrombosis (a condition that occurs when a blood clot forms in a vein deep inside a part of the body) and was treated with heparin (a blood thinner). The resident was discharged from the hospital on 1/3/25. During a confidential telephone interview, on 1/5/2025 at 11:30 A.M., the interviewee indicated the resident and his family members were informed on 12/23/24 that the resident's insurance had "cut" him and would not pay the bill for the resident to stay at the facility. The complainant indicated the resident was not given any prior notice and/or documentation regarding an impending discharge.			

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	During an interview with the SSD, on 1/5/25 at 4:10 P.M., she indicated during the Admission Care Plan Meeting, the resident's sisters had informed her the discharge goal was for the resident to go to a group home setting. She indicated she had informed the sisters that the resident did not have any qualifying diagnoses for a group home admission and the process to admit someone to a group home took up to six months to complete. She indicated the plan was for the resident to discharge to his sister's home but when she notified them on 12/23/24 of the resident's need to be discharged on 12/24/24, both sisters indicated he could not stay with them. She indicated the resident asked to be discharged to the hospital because his car was there. The SSD indicated she told the resident and his sisters he had to leave because he had been discharged from therapy services and the facility had no "skilled" service for him. When asked about his payor source or if there was a letter from the resident's insurance of his notice of eligibility change, the SSD indicated she did not pay attention to resident's payor sources and she was not aware of any "cut" letters (from Resident E's insurance) or any NOMNC (Notice of Medicare/Medicaid Non-Coverage form) being provided for Resident E. When asked if the resident was given a written 30-day discharge notice, the SSD indicated she was not familiar with the form. When asked if the local hospital had been informed of Resident E's desire to be taken to the hospital and if any paperwork had been faxed to the local hospital, the SSD indicated nursing would have taken care of those types of things and she was unsure if any communication had been given to the local hospital regarding Resident E. When asked if there were any more discharge planning notes or documentation for			

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	Resident E, the SSD indicated the only notes were the ones provided in the electronic record progress notes. During an interview, on 1/6/25 at 11:00 A.M., the DON indicated she had completed the discharge forms and instructions for Resident E on 12/24/24. She thought the resident was being discharged due to "an insurance thing," as rehabilitation-wise, the facility had nothing to "skill" him on. The DON had attempted to teach him how to use his PEG tube, but he refused all teaching and refused to take any tube feeding with him because he was going straight to the hospital to have the tube removed. When asked if the hospital was notified of his desire to go to the hospital, and a interfacility transfer set up with the hospital, the DON stated "No, he was being discharged to the hospital parking lot because that was where his car was located." The DON indicated she had sent his prescriptions for medication to a local pharmacy, but the resident told her he was probably not going to go get his medications because he did not have any money for them. She indicated she had sent a three-day supply of medications with him and gave him instructions for the medications. The DON indicated usually the SSD and the Assistant Director of Nursing (ADON) completed discharge planning for residents and she was unsure what planning had been completed for Resident E prior to his discharge from the facility. The week of his discharge, the ADON was on vacation and the DON was not sure what planning the SSD had documented. During an interview, on 1/6/25 at 2:39 P.M., the Administrator indicated the resident was admitted for short-term rehabilitation to home. She understood home was to his sister's home in			

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	Michigan, as the resident was homeless otherwise. The Administrator thought the plan to discharge the resident to his sister's home in Michigan was documented on 12/4/24, but there was no documentation of this plan in the social service or nursing progress notes. The Administrator indicated the resident needed to discharge because he had been discharged from therapy services and the facility was not able to "skill" him for just his gastronomy tube. She then indicated that the resident desired to discharge from the facility before the holidays to spend them with his family. However, there was no social service and/or nursing progress note to support the resident's desire to discharge from the facility on 12/24/24 or any notes leading up to the holidays documenting the resident and/or his family's desire for him to be discharged prior to the holidays. The Administrator indicated the resident's sister in Texas had left a phone message insisting the resident be discharged to the local hospital. However, on 1/6/24 at 4:01 P.M., the Administrator had played part of the audible recorded phone message and the resident's sister clearly stated neither she nor her sister were able to take care of the resident, he was homeless, and she was very upset the facility was "kicking him out" before Christmas. During an interview with the facility transportation staff member, Employee 41, on 1/6/25 at 4:00 P.M., she indicated she had dropped Resident E off by himself at the main entrance to the local hospital and he had walked into the hospital carrying his suitcase. She was not aware of any paperwork sent to the hospital. During an interview with the Regional Administrator, on 1/6/25, she indicated that since the resident was discharged to the hospital, the			

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	155582	A. BUILDING 00 B. WING	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	discharge was safe. During an interview, on 1/7/25 at 12:40 P.M., the interviewee indicated her brother, herself and their other sister were informed on 12/23/24 that the resident needed to discharge because his insurance would not continue to pay. She indicated neither the family nor the resident were given any prior notice and offered any assistance in finding a place of discharge. The facility was informed that neither their sister nor her could get him due to living out of state. He was taken to the hospital and dropped off. None of them knew what else they could do. The resident was seen in the ER on 12/24/24 and was discharged. She indicated the security guard at the hospital was so upset that the resident had no place to go, the security guard bought him a one-night stay at a local hotel. The family did not see the resident until 12/25/24, when he was taken back to the hospital by the family. He was subsequently admitted to the hospital on 12/25/24. She indicated this had been a horrible ordeal for her brother. He was currently in the hospital again with life threatening concerns. Resident E's government-provided insurance eligibility forms indicated Resident E was approved for long-term care skilled care through 12/26/24. The approval dates were given for short-term time periods and Resident E's stay had been approved from his admission through 12/26/24 at the time of his discharge on 12/24/24. The facility policy and procedure, titled "Transfer and Discharge Policy and Procedure" provided by the Administrator as current on 1/6/25 at 9:05 A.M., included the following: "2. Non-emergency transfers or discharges not within the same certified facility will receive notice 30 days before			

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	transfer or discharge. Notice will be given to the resident/responsible party. 3. The written notice will include the following: a. A statement that the resident has the right to appeal the section to State Department of Health including a current phone number of the Department, b. The name, address and telephone number of the State Long Term Care Ombudsman, ...d. A state that, if the resident may appeal the transfer or discharge to the Department of Health within 10 days of being notified of the transfer/discharge 4. The resident may remain in the facility pending an appeal determination or 34 days if the department agrees that the transfer is appropriate...6. The facility will provide provisions for continuity of care and in non-emergency situations a care plan meeting will be held with the appropriate parties to determine a relocation plan... Discharge to Home or lower level of care where resident or family will be administering the resident's medications... 2. The attending physician is required to write a discharge order. Telephone orders are acceptable...Discharge Against Medical Advice 1. When the resident wishes to go home or the resident's family/Responsible Party wishes to take the resident home and the attending physician refuses to give a discharge order a 'Discharge Against Medical Advice' form must be signed by the resident or the resident's representative and placed in the health record. 2. No transfer form completed... 4. The facility should determine the need to contact the appropriate State agencies if the resident's safety is a concern...Emergency Transfer: 1. Obtain physician order for transfer. If the attending physician is not available in an emergency, contact the alternate physician. 2. If the alternate physician is not available, contact the Medical Director. 3. If the Medical Director is not available, contact the Director of Nursing...5. Call ambulance for transfer. 6. Explain transfer and			

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	reason to the resident and/or representative, if applicable send the original State Transfer/Discharge/Bed hold notice with the resident and/or representative or person(s) responsible for care. Place the facility copy in the health record. 7. Complete the Resident Transfer for make 2 copies of any portion of the heath record necessary for care of resident (E.g. Physician's Orders, History & Physical, chest x-ray, Immunization information, any pertinent lab work, etc) 8. Send original of transfer form and portions of health record that was copies with the resident, attach the second copy of the portions of the health record to the facility copy of the transfer form. Give the third copy of the transfer form to the DON...." The immediate jeopardy that began on 12/24/24 was removed on 1/7/25, after the facility completed a complete audit of all discharges in the last three months and educated all licensed nursing staff, the Administrator and social service staff on the transfer discharge policy. The noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because the facility needed to ensure the education was effective by auditing discharges and following up on staff education with further education for the SSD. This citation relates to Complaint IN00448438. 3.1-12(a)(3) 3.1-12(a)(4) 3.1-12(a)(5)(B) 3.1-12(a)(6)(A) 3.1-12(a)(7) 3.1-12(a)(18) 3.1-12(a)(19)			

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	3.1-12(a)(20) 3.1-12(a)(21) 3.1-12(a)(22)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on record review and interview, the facility failed to ensure a notice of discharge was provided, in writing, prior to a facility-initiated discharge for 1 of 3 residents reviewed for discharge. (Resident E) Finding includes: The clinical record for Resident E was reviewed on 1/5/25 at 2:00 P.M. Resident E was admitted to the facility on 11/23/2024 from an acute care facility following surgical repair of necrotizing pancreatitis. The resident's diagnoses, included, but were not limited to, status post (s/p) perforation of the esophagus, acute pancreatitis with uninfected necrosis, gastroesophageal reflux disease with esophagitis, fistula of the stomach and duodenum, and gastrostomy placement. The resident was admitted with physician's orders for enteral tube feedings and nothing by mouth (NPO) except diet soda and medications. The acute care transfer documentation indicated the plan was for the resident to receive nutrition via an enteral tube feeding in the extended care facility until a gastrointestinal surgical consult was completed in four weeks. The resident was to have a Computerized Tomography (CT) scan performed in two weeks. The surgical note indicated in January, the resident's condition was to be reevaluated, a cholecystectomy performed, surgical repair of the resident's intestinal system performed and the G/J tube removed.	F 0623	It is the policy of this facility to ensure a notice of discharge in provided in writing prior to a facility initiated discharge. Resident E re-admitted to the facility on 1/24/2025. All residents who reside in the facility have the potential to be affected by the alleged deficient practice. Therefore, this plan of correction applies to all residents of the facility. Director of Nursing /Designee in-serviced on or before 1/27/25 all nursing staff and social services on the transfer/discharge policy and entering orders to discharge a resident, documentation of discharge planning and education provided to resident and family provide written notice of discharge, documentation to be sent with resident if discharging to hospital. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. The Director of Nursing/Designee will audit residents discharged or transferred to the hospital for physician order, documentation of education, written transfer notice given to resident or representative,	01/28/2025

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	The Admission Minimum Data Set (MDS) assessment, completed on 11/30/24, indicated the resident was admitted for short stay rehabilitation from an acute care facility. An Admission care plan meeting note, completed on 11/29/24 at 11:01 A.M., indicated the resident had attended the meeting and both sisters had participated via telephone. The resident was working with therapy to evaluate his ability to perform his own Activities of Daily Living (ADL) needs and the discharge goal was for the resident to discharge to an assisted living group home setting. There were no recommendations documented as a result of the care plan meeting and no follow-up for discharge planning. A Discharge Care Plan, dated 12/16/24 with a target date of 2/28/25, indicated the resident's goal was to discharge from the facility after short-term stay. The focus indicated the resident planned to return home with a family member. The goals were for the resident to actively participate in therapy, as shown by his attendance and cooperation, and to have a safe discharge home. The only intervention listed for the plan was to assist the resident and family with discharge planning. There was no documentation in the clinical record for discharge planning. There were no nursing and/or social service progress notes regarding discharge needs until a Social Service Note, dated 12/23/24 at 2:35 P.M., indicated the Social Service Director (SSD) spoke with the resident and, via a phone call with one of the resident's sisters, informed the resident and his sister that the facility had nothing to "skill" the resident on, so he needed to leave because his insurance would not pay his bill. The resident informed the SSD he would be living on the		documentation sent with resident upon discharge or transfer to hospital 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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	streets. His sister was asked to come to the facility the following day for some "training and the discharge." The resident's sister indicated she was going to call the "State" and bring them with her. A Social Service note, dated 12/24/24 at 2:25 P.M., indicated one of the resident's sisters had left a phone message that the resident was to be transported to the local hospital because she refused to "take him in." A follow-up entry from the SSD, dated 12/24/2024 at 2:19 P.M., indicated the resident wanted to go to the local hospital to speak with his doctors and then he planned to get a bus ticket out of the state to go to his sister's house. A Nursing Progress Note, dated 12/24/24 at 4:12 P.M., indicated the resident was transported by the facility transporter to the local hospital as requested by the resident. However, a Nursing Progress Note, dated 12/24/24 at 4:14 P.M., indicated the resident was "discharged to home." A Resident Discharge Summary, completed on 12/24/24 by the Director of Nursing (DON), indicated Resident E was discharged to Home/Community accompanied by his family - "sister/family to drive him home." The resident was given discharge instructions and discharged with all of his personal belongings but declined education on his gastronomy tube. The resident was quoted as stating "I am going to be dropped off at [name of local hospital] and they will take it [gastronomy tube] out for me." No community resources were listed and 'None Needed" was marked. Additional comments on the form were as follows, "Resident is discharging because we can no longer skill his services. He has no forwarding address so home health cannot be scheduled."			

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	The resident signed form section indicated a Bed Hold Policy was provided but there was no signed copy of the form located in the clinical record. The physician's orders for Resident E lacked an order to discharge the resident from the facility. There was no documentation in the record to indicate the SSD or any other staff attempted to provide any prior written notice of discharge. Resident E's government-provided insurance eligibility forms indicated Resident E was approved for long-term care skilled care through 12/26/24. The approval dates were given for short-term time periods and Resident E's stay had been approved from his admission through 12/26/24 at the time of his discharge on 12/24/24. During a confidential telephone interview, on 1/5/2025 at 11:30 A.M., the interviewee indicated indicated the resident and his family members were informed on 12/23/24 that the resident's insurance had "cut" him and would not pay the bill for the resident to stay at the facility. The complainant indicated the resident was not given any prior notice and/or documentation regarding an impending discharge. During an interview with the SSD, on 1/5/25 at 4:10 P.M., she indicated during the Admission Care Plan Meeting, the resident's sisters had informed her the discharge goal was for the resident to go to a group home setting. She indicated she had informed the sisters that the resident did not have any qualifying diagnoses for a group home admission and the process to admit someone to a group home took up to six months to complete. She indicated the plan was for the resident to discharge to his sister's home			

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	but when she notified them on 12/23/24 of the resident's need to be discharged on 12/24/24, both sisters indicated he could not stay with them. She indicated the resident asked to be discharged to the hospital because his car was there. The SSD indicated she told the resident and his sisters he had to leave because he had been discharged from therapy services and the facility had no "skilled" service for him. When asked about his payor source or if there was a letter from the resident's insurance of his notice of eligibility change, the SSD indicated she did not pay attention to resident's payor sources and she was not aware of any "cut" letters (from Resident E's insurance) or any NOMNC (Notice of Medicare/Medicaid Non-Coverage form) being provided for Resident E. When asked if the resident was given a written 30-day discharge notice, the SSD indicated she was not familiar with the form. When asked if the local hospital had been informed of Resident E's desire to be taken to the hospital and if any paperwork had been faxed to the local hospital, the SSD indicated nursing would have taken care of those types of things and she was unsure if any communication had been given to the local hospital regarding Resident E. When asked if there were any more discharge planning notes or documentation for Resident E, the SSD indicated the only notes were the ones provided in the electronic record progress notes. During an interview, on 1/6/25 at 11:00 A.M., the DON indicated she had completed the discharge forms and instructions for Resident E on 12/24/24. She thought the resident was being discharged due to "an insurance thing," as rehabilitation-wise, the facility had nothing to "skill" him on. The DON had attempted to teach him how to use his PEG tube, but he refused all			

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	teaching and refused to take any tube feeding with him because he was going straight to the hospital to have the tube removed. When asked if the hospital was notified of his desire to go to the hospital, and a interfacility transfer set up with the hospital, the DON stated "No, he was being discharged to the hospital parking lot because that was where his car was located." The DON indicated usually the SSD and the Assistant Director of Nursing (ADON) completed discharge planning for residents and she was unsure what planning had been completed for Resident E prior to his discharge from the facility. The week of his discharge, the ADON was on vacation and the DON was not sure what planning the SSD had documented. The DON indicated generally, short-term residents were not given a 30-day notice. During an interview, on 1/6/25 at 2:39 P.M., the Administrator indicated the resident was admitted for short-term rehabilitation to home. The resident needed to discharge because he had been discharged from therapy services and the facility was not able to "skill" him for just his gastronomy tube. She then indicated that the resident desired to discharge from the facility before the holidays to spend them with his family. However, there was no social service and/or nursing progress note to support the resident's desire to discharge from the facility on 12/24/24 or any notes leading up to the holidays documenting the resident and/or his family's desire for him to be discharged prior to the holidays. The Administrator indicated the resident's sister in Texas had left a phone message insisting the resident be discharged to the local hospital. However, on 1/6/24 at 4:01 P.M., the Administrator had played part of the audible recorded phone message and the resident's sister clearly stated neither she nor her sister were able			

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	to take care of the resident, he was homeless, and she was very upset the facility was "kicking him out" before Christmas. During an interview with the facility transportation staff member, Employee 41, on 1/6/25 at 4:00 P.M., she indicated she had dropped Resident E off by himself at the main entrance to the local hospital and he had walked into the hospital carrying his suitcase. She was not aware of any paperwork sent to the hospital. The facility policy and procedure, titled "Transfer and Discharge Policy and Procedure" provided by the Administrator as current on 1/6/25 at 9:05 A.M., included the following: "2. Non-emergency transfers or discharges not within the same certified facility will receive notice 30 days before transfer or discharge. Notice will be given to the resident/responsible party. 3. The written notice will include the following: a. A statement that the resident has the right to appeal the section to State Department of Health including a current phone number of the Department, b. The name, address and telephone number of the State Long Term Care Ombudsman, ...d. A state that, if the resident may appeal the transfer or discharge to the Department of Health within 10 days of being notified of the transfer/discharge 4. The resident may remain in the facility pending an appeal determination or 34 days if the department agrees that the transfer is appropriate...6. The facility will provide provisions for continuity of care and in non-emergency situations a care plan meeting will be held with the appropriate parties to determine a relocation plan... Discharge to Home or lower level of care where resident or family will be administering the resident's medications... 2. The attending physician is required to write a discharge order. Telephone orders are			

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	acceptable...Discharge Against Medical Advice 1. When the resident wishes to go home or the resident's family/Responsible Party wishes to take the resident home and the attending physician refuses to give a discharge order a 'Discharge Against Medical Advice' form must be signed by the resident or the resident's representative and placed in the health record. 2. No transfer form completed... 4. The facility should determine the need to contact the appropriate State agencies if the resident's safety is a concern...Emergency Transfer: 1. Obtain physician order for transfer. If the attending physician is not available in an emergency, contact the alternate physician. 2. If the alternate physician is not available, contact the Medical Director. 3. If the Medical Director is not available, contact the Director of Nursing...5. Call ambulance for transfer. 6. Explain transfer and reason to the resident and/or representative, if applicable send the original State Transfer/Discharge/Bed hold notice with the resident and/or representative or person(s) responsible for care. Place the facility copy in the health record. 7. Complete the Resident Transfer for make 2 copies of any portion of the heath record necessary for care of resident (E.g. Physician's Orders, History & Physical, chest x-ray, Immunization information, any pertinent lab work, etc) 8. Send original of transfer form and portions of health record that was copies with the resident, attach the second copy of the portions of the health record to the facility copy of the transfer form. Give the third copy of the transfer form to the DON...." There was no documentation in the record to indicate a 30-day notice was issued to Resident E prior to his facility-initiated discharge. The resident was also erroneously informed his insurance would not pay for his stay, when he			

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	had insurance coverage through 12/26/24. There was no signed copy of the Bed Hold policy located in the resident's medical record upon his discharge from the facility on 12/23/24. This citation relates to Complaint IN00448438. 3.1-12(a)(5)(A) 3.1-12(a)(7) 3.1-12(a)(9)			
F 0624 SS=D Bldg. 00	483.15(c)(7) Preparation for Safe/Orderly Transfer/Dschrg Based on record review and interview, the facility failed to ensure preparation and orientation for a resident's discharge was completed to minimize anxiety and ensure a safe and orderly discharge from the facility for 1 of 3 residents reviewed for discharge planning. (Resident E) Finding includes: The clinical record for Resident E was reviewed on 1/5/25 at 2:00 P.M. Resident E was admitted to the facility on 11/23/24 from an acute care facility following surgical repair of necrotizing pancreatitis. The resident's diagnoses included, but were not limited to, status post (s/p) perforation of the esophagus, acute pancreatitis with uninfected necrosis, gastroesophageal reflux disease with esophagitis, fistula of the stomach and duodenum, and gastrostomy placement. The resident was admitted with physician orders for enteral tube feedings and nothing by mouth (NPO) except diet soda and medications. The acute care transfer documentation indicated the plan was for the resident to receive nutrition via an enteral tube feeding in the extended care facility until a gastrointestinal surgical consult	F 0624	It is the policy of the facility to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. Resident E re-admitted to the facility on 1/24/2025. All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents that reside in the facility. DON/Designee on or before 1/27/25 in-serviced all nursing staff and social services on the transfer/discharge policy and entering orders to discharge a resident, documentation of discharge planning and education provided to resident and family provide written notice of discharge, documentation to be sent with resident if discharging to hospital. Additionally, any staff that fails to comply with the points of this	01/28/2025

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	was completed in four weeks. The resident was to have a Computerized Tomography (CT) scan performed in two weeks. The surgical note indicated in January, the resident's condition was to be reevaluated, a cholecystectomy performed, surgical repair of the resident's intestinal system performed and the G/J tube removed. The Admission Minimum Data Set (MDS) assessment, completed on 11/30/24, indicated the resident was admitted for short stay rehabilitation from an acute care facility. The assessment indicated the resident was cognitively intact, had not displayed any mood issues or behaviors during the assessment period, was dependent on staff for feeding due to requiring enteral feedings, utilized a walker and/or wheelchair for mobility needs, required moderate staff assistance for lower body dressing, applying footwear, and bathing needs, received physical and occupational therapy and did not require an active discharge plan. An Admission Care plan meeting note, completed on 11/29/24 at 11:01 A.M., indicated the resident attended the meeting and both sisters had participated via telephone. The resident was working with therapy to evaluate his ability to perform his own Activities of Daily Living (ADL) needs and the discharge goal was for the resident to discharge to an assisted living group home setting. There were no recommendations documented as a result of the care plan meeting. There was no further follow-up with discharge planning. A Discharge care plan for Resident E, dated 12/16/24 with a target date of 2/28/25, indicated the resident's goal was to discharge from the facility after a short-term stay. The focus indicated		in-service will be further educated and/or disciplined as indicated. The DON/Designee will audit residents discharged or transferred to the hospital for physician order, documentation of education, written transfer notice given to resident or representative, documentation sent with resident upon discharge or transfer to hospital 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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	the resident planned to return home with a family member. The goals were for the resident to actively participate in therapy, as shown by his attendance and cooperation, and to have a safe discharge home. The only intervention listed for the plan was to assist the resident and family with discharge planning. There were no nursing and/or social service progress notes regarding discharge needs until a Social Service Note, dated 12/23/24 at 2:35 P.M., indicated the Social Service Director (SSD) spoke with the resident and, via a phone call with one of the resident's sisters, informed the resident and his sister that the facility had nothing to "skill" the resident on, so he needed to leave because his insurance would not pay his bill. The resident informed the SSD he would be living on the streets. His sister was asked to come to the facility the following day for some "training and the discharge." The resident's sister indicated she was going to call the "State" and bring them with her. A Social Service Note, dated 12/24/24 at 2:25 P.M., indicated one of the resident's sisters had left a phone message that the resident was to be transported to the local hospital because she refused to "take him in." A follow-up entry from the SSD, dated 12/24/24 at 2:19 P.M., indicated the resident wanted to go to the local hospital to speak with his doctors and then he planned to get a bus ticket out of the state to go to his sister's. There was no documentation in the record that indicated the resident had any prior communication about wanting to discharge until he was informed he would have to leave. The physician's orders for Resident E lacked an order to discharge the resident from the facility.			

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During an interview, on 1/6/25 at 3:36 P.M., the Medical Director indicated he had not been notified nor had any record of ordering a discharge for Resident E.

A Nursing Progress Note, dated 12/24/24 at 4:12 P.M., indicated the resident was transported by the facility transporter to the local hospital as requested by the resident. However, a Nursing Progress Note, dated 12/24/24 at 4:14 P.M., indicated the resident was "discharged to home."

A Resident Discharge Summary, completed on 12/24/24 by the Director of Nursing (DON), indicated Resident E was discharged to Home/Community accompanied by his family - "sister/family to drive him home." The resident was given discharge instructions and discharged with all of his personal belongings but declined education on his gastronomy tube. The resident was quoted as stating "I am going to be dropped off at [name of local hospital] and they will take it [gastronomy tube] out for me." No community resources were listed and 'None Needed" was marked. Additional comments on the form were as follows, "Resident is discharging because we can no longer skill his services. He has no forwarding address so home health cannot be scheduled."

A (Name of Hospital) Physician's Note indicated the resident arrived at the hospital on 12/25/24 at 4:27 P.M., after making suicidal statements. The documentation indicated the resident had been in the acute care facility for a prolonged stay, was discharged to the long-term care facility with tube feedings to be continued, and a GI (gastrointestinal) physician follow-up to have occurred in January 2025. The resident was discharged from the long-term care facility but

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	was homeless with nothing set up for his tube feedings. The note indicated he was unable to go to any of the homeless shelters in the area due to the tube feeding, and so he had presented to the emergency department feeling "hopeless." The emergency room note indicated the resident was not able to take in nutrition orally and had complex social issues. During a confidential telephone interview, on 1/5/2025 at 11:30 A.M., the interviewee indicated the resident and his family members were informed on 12/23/24 that the resident's insurance had "cut" him and would not pay the bill for the resident to stay at the facility. The resident was not given any prior notice and/or documentation regarding an impending discharge. During an interview with the SSD, on 1/5/25 at 4:10 P.M., she indicated during the Admission Care Plan Meeting, the resident's sisters had informed her the discharge goal was for the resident to go to a group home setting. She indicated she had informed the sisters that the resident did not have any qualifying diagnoses for a group home admission and the process to admit someone to a group home took up to six months to complete. She indicated the plan was for the resident to discharge to his sister's home but when she notified them on 12/23/24 of the resident's need to be discharged on 12/24/24, both sisters indicated he could not stay with them. She indicated the resident asked to be discharged to the hospital because his car was there. The SSD indicated she told the resident and his sisters he had to leave because he had been discharged from therapy services and the facility had no "skilled" service for him. When asked about his payor source or if there was a letter from the resident's insurance of his notice of eligibility			

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	change, the SSD indicated she did not pay attention to resident's payor sources and she was not aware of any "cut" letters (from Resident E's insurance) or any NOMNC (Notice of Medicare/Medicaid Non-Coverage form) being provided for Resident E. When asked if the resident was given a written 30-day discharge notice, the SSD indicated she was not familiar with the form. When asked if the local hospital had been informed of Resident E's desire to be taken to the hospital and if any paperwork had been faxed to the local hospital, the SSD indicated nursing would have taken care of those types of things and she was unsure if any communication had been given to the local hospital regarding Resident E. When asked if there were any more discharge planning notes or documentation for Resident E, the SSD indicated the only notes were the ones provided in the electronic record progress notes. During an interview, on 1/6/25 at 11:00 A.M., the DON indicated she had completed the discharge forms and instructions for Resident E on 12/24/24. She thought the resident was being discharged due to "an insurance thing," as rehabilitation-wise, the facility had nothing to "skill" him on. The DON had attempted to teach him how to use his PEG tube, but he refused all teaching and refused to take any tube feeding with him because he was going straight to the hospital to have the tube removed. When asked if the hospital was notified of his desire to go to the hospital, and a interfacility transfer set up with the hospital, the DON stated "No, he was being discharged to the hospital parking lot because that was where his car was located." The DON indicated she had sent his prescriptions for medication to a local pharmacy, but the resident told her he was probably not going to go get his			

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	medications because he did not have any money for them. She indicated she had sent a three-day supply of medications with him and gave him instructions for the medications. The DON indicated usually the SSD and the Assistant Director of Nursing (ADON) completed discharge planning for residents and she was unsure what planning had been completed for Resident E prior to his discharge from the facility. The week of his discharge, the ADON was on vacation and the DON was not sure what planning the SSD had documented. The DON indicated generally, short term residents were not given a 30 day notice, but Resident E should have been given a NOMNC when he was discharged from rehab (rehabilitation) services. She was not sure if the SSD had issued the form. During an interview, on 1/6/25 at 2:39 P.M., the Administrator indicated the resident was admitted for short-term rehabilitation to home. She understood home was to his sister's home in Michigan, as the resident was homeless otherwise. The Administrator thought the plan to discharge the resident to his sister's home in Michigan was documented on 12/4/24, but there was no documentation of this plan in the social service or nursing progress notes. The Administrator indicated the resident needed to discharge because he had been discharged from therapy services and the facility was not able to "skill" him for just his gastronomy tube. She then indicated that the resident desired to discharge from the facility before the holidays to spend them with his family. However, there was no social service and/or nursing progress note to support the resident's desire to discharge from the facility on 12/24/24 or any notes leading up to the holidays documenting the resident and/or his family's desire for him to be discharged prior to			

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	the holidays. The Administrator indicated the resident's sister in Texas had left a phone message insisting the resident be discharged to the local hospital. However, on 1/6/24 at 4:01 P.M., the Administrator had played part of the audible recorded phone message and the resident's sister clearly stated neither she nor her sister were able to take care of the resident, he was homeless, and she was very upset the facility was "kicking him out" before Christmas. During an interview with the facility transportation staff member, Employee 41, on 1/6/25 at 4:00 P.M., she indicated she had dropped Resident E off by himself at the main entrance to the local hospital and he had walked into the hospital carrying his suitcase. She was not aware of any paperwork sent to the hospital. The facility policy and procedure, titled "Transfer and Discharge Policy and Procedure" provided by the Administrator as current on 1/6/25 at 9:05 A.M., included the following: "2. Non-emergency transfers or discharges not within the same certified facility will receive notice 30 days before transfer or discharge. Notice will be given to the resident/responsible party. 3. The written notice will include the following: a. A statement that the resident has the right to appeal the section to State Department of Health including a current phone number of the Department, b. The name, address and telephone number of the State Long Term Care Ombudsman, ...d. A state that, if the resident may appeal the transfer or discharge to the Department of Health within 10 days of being notified of the transfer/discharge 4. The resident may remain in the facility pending an appeal determination or 34 days if the department agrees that the transfer is appropriate...6. The facility will provide provisions for continuity of care and in			

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	non-emergency situations a care plan meeting will be held with the appropriate parties to determine a relocation plan... Discharge to Home or lower level of care where resident or family will be administering the resident's medications... 2. The attending physician is required to write a discharge order. Telephone orders are acceptable...Discharge Against Medical Advice 1. When the resident wishes to go home or the resident's family/Responsible Party wishes to take the resident home and the attending physician refuses to give a discharge order a 'Discharge Against Medical Advice' form must be signed by the resident or the resident's representative and placed in the health record. 2. No transfer form completed... 4. The facility should determine the need to contact the appropriate State agencies if the resident's safety is a concern...Emergency Transfer: 1. Obtain physician order for transfer. If the attending physician is not available in an emergency, contact the alternate physician. 2. If the alternate physician is not available, contact the Medical Director. 3. If the Medical Director is not available, contact the Director of Nursing...5. Call ambulance for transfer. 6. Explain transfer and reason to the resident and/or representative, if applicable send the original State Transfer/Discharge/Bed hold notice with the resident and/or representative or person(s) responsible for care. Place the facility copy in the health record. 7. Complete the Resident Transfer for make 2 copies of any portion of the heath record necessary for care of resident (E.g. Physician's Orders, History & Physical, chest x-ray, Immunization information, any pertinent lab work, etc) 8. Send original of transfer form and portions of health record that was copies with the resident, attach the second copy of the portions of the health record to the facility copy of the transfer form. Give the third copy of the transfer			

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	form to the DON...." There was no documentation in the record to indicate the facility provided appropriate preparation or orientation to Resident E to ensure a safe discharge. This citation relates to Complaint IN00448438. 3.1-12(a)(3) 3.1-12(a)(18) 3.1-12(a)(19) 3.1-12(a)(20) 3.1-12(a)(21) 3.1-12(a)(22) 3.1-12(a)(23)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview and record review, the facility failed to ensure dependent residents had received bathing opportunities according to their twice a week preferences for 2 of 3 residents reviewed for bathing. (Resident R and Resident X) Findings include: 1. During an interview, on 1/6/25 at 10:00 A.M., Resident R indicated there was only one aide on the floor and she had not received a shower in 2-3 weeks. The last time her hair had been shampooed had also been 2-3 weeks ago. The resident indicated her showers had been scheduled for Wednesdays and Saturdays. This past Saturday, the aide had indicated to the resident she was ready to assist with her shower, but it had been during lunch time, so the resident requested to have her shower after lunch. The aide never	F 0677	It is the intent of this facility to ensure dependent residents receive a bathing opportunity according to their twice a week preference. All residents in the facility received a shower per preference. Residents were interviewed for shower preferences and care plan updated with preferences on ----------or before 1/27/25 by DON/ Designee. Shower schedule was updated as appropriate. DON/Designee completed an audit for shower preferences on or before 1/27/25 and care plans were updated and shower schedule updated. The DON/Designee in-serviced the	01/28/2025

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	returned to provide her a shower. On 1/6/25 at 11:35 A.M., a review of the clinical record for Resident R was conducted. The resident's diagnoses included, but were not limited to, cerebrovascular accident (CVA), heart failure, colostomy status and anxiety. An Activity Admission Evaluation, dated 7/5/24, indicated the resident preferred a shower. The Quarterly Minimum Data Set (MDS) assessment, dated 10/6/24, indicated the resident's cognition was intact, had no rejection of care behaviors and required partial/moderate assist with showering/bathing. A Care Plan, dated 10/16/24, indicated the resident required assistance with ADLs (Activities of Daily Living). The interventions included, but were not limited to, encourage the resident to complete as much as they can, extensive assist of one person needed for transfer,s and bathe resident per the resident's preference twice a week. There was no care plan indicating the resident had a pattern of refusal of care. A form, titled "Shower Report," indicated on the following dates the resident was offered a shower in December 2024 and January 2025: - 12/4/24 a Wednesday- indicated resident refused a shower. - 12/7/24 a Saturday-indicated the resident received a shower, with shampoo, lotion and nail care. - 12/11/24 a Wednesday-indicated the resident refused a shower. - 12/14/24 a Saturday- indicated the resident refused a shower. - 12/18/24 a Wednesday-indicated the resident		nursing staff on or before 1/27/25 on the Shower Policy to ensure showers are being offered on shower days and shower sheets are filled out in their entirety. Additionally, any staff that fails to comply with the point of this in-service will be further educated and/or disciplined as indicated. DON/Designee will complete an audit tool labeled “Resident Shower Audit Tool” on 20 random residents weekly x 4 weeks, then 10 random residents weekly x 4 weeks, then 5 random residents monthly x 4 months for showers proved per residents’ preference. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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	refused as she had a shower on 12/17/24, however there was no shower sheet for that day. - 12/21/24 a Saturday-indicated the resident refused a shower. - 12/29/24 a Sunday-indicated the resident received a shower and shampoo - 1/1/25 a Wednesday-indicated the resident refused a shower. There was no shower sheet for 1/4/25 provided. A form titled, "Documentation Survey Report for December 2024 and January 2025", was provided by the Director of Nursing. The form indicated the resident had a shower on the following days: 12/4, 12/7, 12/18 and none recorded for January 2025. The 12/7 shower report indicated no shampoo had been completed for the resident. 2. On 1/5/25 at 10:43 A.M., Resident X's son indicated he had concerns about the lack of showers provided by the facility staff. During an observation, on 1/5/25 at 10:53 A.M., Resident X was observed in bed, she was alert to her name but unable to recall what day it was. The room had an odor of stool. CNA 29 knocked on the resident's door and entered with supplies to change the resident. The CNA was observed to assist the resident and change her brief without concerns noted. On 1/7/25 at 2:53 P.M., a review of the clinical record for Resident X was conducted. The record indicated the resident was admitted on 11/18/24. The resident's diagnoses included, but were not limited to; dementia, osteoporosis, difficulty walking and weakness. The Admission Minimum Data Set (MDS)			

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	assessment, dated 11/22/24, indicated the resident's cognition was moderately impaired and required partial/moderate assistance of 1 person's with a shower. An Activity Admission Evaluation, dated 11/18/24, indicated the resident preferred a shower. The Care Plan for preferences, dated 11/20/24, indicated the resident a shower twice a week but care plan did not indicate what days the showers would occur. The ADL care plan was not received. A form titled "Shower Report" indicated on the following dates the resident was offered a shower in December 1014 and January 2025: - 11/24/24 a Sunday indicated the resident had a shower but did not want her hair washed. - 11/27/24 a Wednesday indicated the resident had refused a shower 3 times so staff provided a complete bed bath. - 12/12/24 a Thursday indicated the resident had a shower and shampoo - 12/23/24 a Monday indicated the resident had a shower and shampoo There were no shower reports provided for January 2025. A form titled, "Documentation Survey Report for November 2024, December 2024 and January 2025", was provided by the Director of Nursing. The form indicated the resident had a shower on 11/23/24 and 1/6/25. The form indicated she received a bed bath on 11/27/24, 12/10/24 and 12/22/24. A form titled "Sunshine Pod Showers", indicated Resident X should have received her showers on			

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	155582	A. BUILDING 00 B. WING	01/08/2025

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	Mondays and Thursdays. On 1/6/25 at 4:04 P.M., the Regional Nurse Consultant provided a policy titled, "Guidelines for Bathing", dated 9/21/23, and indicated the policy was the one currently used by the facility. The policy indicated "...To cleanse the skin and to promote circulation...." On 1/7/25 at 11:02 A.M., the Regional Nurse Consultant indicated the facility had no ADL policy related to showers or bathing opportunities. This citation relates to Complaint IN00450476. 3.1-38(a)(3) 3.1-38(b)(2) 3.1-38(b)(3)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, interview and record review, the facility failed to ensure tube feedings were documented as ordered by the physician for 2 of 3 residents reviewed for tube feeding. (Resident E and Resident S) Findings include: 1. The clinical record for Resident E was reviewed on 1/5/25 at 2:00 P.M. Resident E was admitted to the facility on 11/23/24 from an acute care facility following surgical repair of necrotizing pancreatitis. The resident's diagnoses included, but were not limited to, status post (s/p) perforation of the esophagus, acute pancreatitis with uninfected necrosis, gastroesophageal reflux disease with esophagitis, fistula of the stomach	F 0693	It in the intent of this facility to ensure tube feedings are documented as ordered by the physician. Resident E returned to the facility on 1/24/25 and no longer requires tube feedings per physician orders. On 1/6/25 resident S's piston syringe and water bottle discarded, and a new piston syringe and water bottle dated and put in place by the DON/Designee. The DON/Designee assessed Resident S and no negative outcome related to the alleged deficient practice on 1/6/25.	01/28/2025

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	and duodenum, and gastrostomy placement. The resident had a gastrostomy/jejunostomy tube (a GJ tube - combination of a tube placed in the stomach and a tube placed in the jejunum that is secured with a balloon or plastic bumper in the stomach and a plastic disc around the outside of the body.) The resident was admitted with physician orders for enteral tube feedings and nothing by mouth (NPO) except diet soda and medications. The Admission Minimum Data Set (MDS) assessment, dated 11/30/24, indicated the resident was cognitively intact, was dependent on staff for feedings, required enteral feedings and received 51% or more of his total calories via a J-tube. A Care Plan, dated 11/25/24, indicated the resident had the inability to tolerate oral intake and had a jejunostomy in place for nutrition. The interventions included, but were not limited to, Give J-tube feeding as ordered, monitor J-tube site daily for signs of infection and report any problems to the physician. A Registered Dietician Note, dated 11/25/24 at 4:41 P.M., indicated Resident E was admitted from the hospital and a J-tube had been placed for feedings. The note indicated "...Diet: NPO except ice chips and diet soda. Enteral Feed: current order is 4a-12p feed with no rate indicated, 60 ml flush q [every] shift. Review: Resident requiring enteral feeds via PEGJ tube for pancreatic rest post pancreatitis. J port (yellow) must be used for feeds. Noted per hospital notes resident can have ice chips and diet coke by mouth. Resident is mobile and would like some daytime off feed to move around facility etc. Resident will transition to [name of enteral feed] 1.5 per facility availability...[name of enteral feed] 1.5 total		All residents requiring tube feedings have the potential to be affected by the alleged deficient practice. DON/ Designee completed an audit of physician orders for all residents with tube feedings. All care plans were reviewed and revised as necessary on 1/13/25. The DON/Designee in-serviced the Nursing staff on guidelines for enteral tube feeding and documentation on or before 1/27/25. Additionally, any staff that fails to comply with the point of the in-service will be further educated and/or disciplined as indicated. DON/Designee will complete an titled “Enteral Feed Audit Tool” five times a week for 4 weeks for documentation of tube feeding administration on EMAR and dating of piston syringe and water bottle, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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	volume of 1575 per day provides: 2362 kcals/106 g protein/1202 ml free water. Tube flushed for patency before and after feeds. Meets 100% of assessed calories and protein needs. Resident to take water orally to meet fluids needs...." An Order Summary Report, indicated the following: "...Enteral Feed Order every shift for supplemental feed Start 4am and end midnight 105ml/hr [milliliters per hour]. Flush before and after feed w [with] 60 ml of water...." Start date was 11/27/24. There was no end date documented "...Enteral Feed Order every shift for supplemental feed [name of enternal feed] 105 ml/hr 12pm-2pm total volume Start 6pm to 7am 105 ml/hr. total volume 1365ml Flush before and after feed w [with] 60ml of water...." Start date was 12/5/24. The Medication Administration Record (MAR) for November 2024 indicated "...[Name of enteral feeding] 1.5 on at 0400 off at midnight. Flush with water before and after each feeding...." Start date 11/23/24 with end date 11/27/24. Nurses initialed the MAR day, evening and night shift; however, there was no documentation on the MAR or Treatment Administration Record (TAR) which indicated the enteral feeding was started at 4:00 A.M., stopped at midnight, nor the amount the resident received during the eternal feeding. There were initials on 11/27/2, by the day nurse; however, starting 11/28/24, there were no other notes or initials on the November MAR indicating the resident had received his enteral feedings. The December MAR & TAR had no documentation related to the enteral feedings. The November and December 2024 MAR indicated "NPO [nothing by mouth] except meds,			

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	ice chips or diet soda only by mouth...." Nurses were documenting the resident was NPO on the November and December MAR with start date of 11/23/24 and end date 12/24/24. During an interview, on 1/8/25 at 11:09 A.M., the Director of Nursing (DON) indicated she had not found other documentation of the enteral feeding for Resident E and indicated it would have been documented on the MAR/TAR. 2. On 1/6/25 at 10:47 A.M., a review of the clinical record for Resident S was conducted. The resident's diagnoses, included but were not limited to, Alzheimer's Disease, diabetes and dysphagia (difficulty swallowing). A Quarterly Minimum Data Set (MDS) assessment, dated 10/25/24, indicated the resident's cognition was severely impaired, received partial to moderate assistance with eating and received 51% or more of total calories via g-tube. (Gastrostomy tube is an opening in the stomach to insert a tube for nutritional support) A Care Plan, dated 6/13/24, indicated the resident had a diagnosis of dysphasia and had a G-tube in place for nutrition. The interventions included, but were not limited to, Give G-tube feeding as ordered, monitor G-tube site daily for signs of infection and flush G-tube as ordered. Physician Orders included the following: - 4/5/2024 Enteral feed, five times a day, for G-Tube Isosource 1.5, administer 237ml (milliliters). - 6/14/2024 Piston and container for G-Tube to be changed each night shift. Please make sure you date and initial every night shift.			

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	The Enteral and Oral Supplement record, dated December 2024, indicated "...Enteral Feed Order five times a day for G-Tube Isosource 1.5cal [calores] give 237 mL. then flush with 30cc [cubic centimeter] before and after feeding...." The record indicated the times for the feeding were midnight, 8:00 A.M., noon, 4:00 P.M. and 8:00 P.M. The record indicated the resident did not receive enteral feeding on the following dates and times: -12/4/24 at 12:00 A.M. -12/4/24 at 4:00 P.M. -12/6/24 at 12:00 A.M. -12/13/24 at 12:00 A.M. -12/13/24 at 8:00 P.M. -12/14/24 at 4:00 P.M. -12/14/24 at 8:00 P.M. -12/18/24 at 8:00 P.M. -12/20/24 at 12:00 A.M. -12/20/24 at 4:00 P.M. -12/20/24 at 8:00 P.M. -12/22/24 at 4:00 P.M. -12/23/24 at 8:00 P.M. -12/23/24 at 4:00 P.M. -12/24/24 at 8:00 P.M. -12/24/24 at 4:00 P.M. -12/25/24 at 8:00 P.M. -12/25/24 at 4:00 P.M. -12/27/24 at 12:00 A.M. During an observation with LPN 21, on 1/6/25 at 11:25 A.M., the resident's piston syringe (device for administrating the G-tube formula) and water bottle were not dated. LPN 21 indicated both the piston's package covering and water bottle should have been dated. The night shift was responsible for throwing out both the piston syringe and bottle, replacing them with new devices and dating the equipment. LPN 21 indicated Resident S did not refuse any tube feedings.			

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	During an interview, on 1/6/25 at 2:31 P.M., the DON indicated the nursing staff should have documented each time a bolus feeding was administered. The blanks on the Enteral Oral Supplement record indicated that it was not signed and/or not administered as ordered. On 1/6/25 at 2:57 P.M., the Regional Nurse Consultant provided a policy titled, "Guidelines for Enteral Feeding: Adult", dated 7/3/23, and indicated the policy was the one currently used by the facility. The policy indicated "...Purpose: To provide guidance to qualified licensed clinical staff in hanging and maintaining and managing and administering Tube/Feeding and Enteral Nutrition-to residents to include medication administration...The feeding bag/tubing must be changed every 24 hours...." The Regional Nurse indicated the policy was the only one pertaining to enteral feeding. The policy did not indicate where or when to document the enteral feeding. A documentation policy was requested. On 1/6825 at 10:28 A.M., the Administrator provided a policy titled, "Guidelines for Nursing Documentation", dated 5/17/23 and indicated the policy was the one currently used by the facility. The policy indicated "...9. Remember "If you did not write it down, you did not do it...." This citation relates to Complaint IN00448438. 3.1-44(a)(2)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on observation, interview and record review, the facility failed to ensure nurse staffing	F 0732	It is the intent of this facility to ensure nurse staffing information	01/28/2025

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	information was posted for the residents and their families to review. This had the ability to affect all of the residents and their family members. Finding includes: On 1/2/25 at 3:39 P.M., a posting of a form titled, "Nursing Staff Directly Responsible For Resident Care", dated 11/18/24, was observed near the entrance to the facility behind a glass case. The form indicated how many Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nurse Aides (CNA) were working in a 24 hour period. The bottom of the form indicated, "...Daily posting of this information is required for nursing participation in Medicare and Medicaid...." On 1/2/25 at 4:46 P.M., the Director of Nursing (DON) observed the nurse staff posting and indicated this was the only place the form was displayed in the facility. The DON confirmed the date on the form was 11/18/24 and indicated it was the scheduler's job to post the nurse staffing daily. During an interview, on 1/2/25 at 5:09 P.M., the Administrator indicated it was the DON and Assistant Director of Nursing's responsibility to post the daily nurse staffing since the facility currently did not have a scheduler. On 1/2/25 at 5:12 P.M., the DON provided a policy titled, "Guidelines for BIPA Staffing Posting Requirement", dated 7/24/23 and indicated the policy was the one currently used by the facility. The policy indicated "...It is the policy of the facility, in cooperation with Medicare/Medicaid Services, (CMS), to comply with the requirement of daily posting of nursing staff in the facility...."		is posted for residents and their families to review. There were not residents affected by this alleged cited practice. All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents that reside in the facility. The Regional Nurse Consultant/Designee completed education with facility scheduler, Director of Nursing and Nursing Managers on posting nursing staffing information daily on 1/24/25. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. The Administrator/designee will complete daily staffing posting audits 5x's a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 weeks, then once a month x 3 months for current daily staffing posted. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator	

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			weekly until resolved.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview and record review, the facility failed to ensure hot food and cold liquids were served and maintained in a sanitary and safe manner related to staff touching food and other items both with the same gloved hands during meal service and not keeping room tray meal cart food at the proper serving temperature during two random food service observations. (Main Kitchen and ICF/Maple Unit) This had the potential to affect all residents who received food and drinks from the kitchen. Findings include: 1. During dinner service on 1/3/25 at 5:30 P.M. - 5:33 P.M., the following was observed from the entrance to kitchen: The Dietary Manager (DM) and Dietary Aide 28 were in the kitchen wearing blue gloves which covered their hands. The DM took one gloved hand, grabbed a plate and removed a piece of fish from the steamer pan with her other gloved hand. Then, with the same hand, scooped up a serving of carrots with a ladle and continued down the steamer with the same gloved hands, touching each ladle. The DM placed the plate on a tray and took it to an open counter, which she touched with her gloved hand, to be picked up by a facility staff member who served the tray to a resident. Dietary Aide #28 followed behind the DM and was observed taking his blue gloved hand, grabbing a plate and removing a piece of fish from the steam pan with his gloved hand, then placing the fish on a plate. He then added the carrots and on down the steamer touching the ladle handles with the same gloved	F 0812	It is the intent of this facility to ensure hot food and cold liquids are served and maintained in a sanitary and safe manner. The DON/Designee assessed residents on 1/6/25 and no negative outcome related to the alleged deficient practice. All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents that reside in the facility. The Adm/Designee in-serviced the dietary on the following. 1.Glove and Hand Washing Procedures. 1.Cooking Food Temperatures and Holding Times 1.Handling Food in a Sanitary and Safe Manner Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. The Dietary Manager or Designee will audit 10 random meal services weekly to ensure dietary staff are handling food in a sanitary and safe manner and using appropriate utensils to serve food and food temperatures are maintained during serving and while serving on hallways, then 5 random meals	01/28/2025

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	hands, and placed the plate on a tray to be distributed to a resident. As Dietary Aide 28 returned to the steam table, the DM repeated the same process with the same gloved hands, as did Dietary Aide 28 again. On 1/3/25 at 5:34 P.M., the DM indicated she had placed a set of tongs in the pan of fish and should have used the tongs to remove the fish from the pan instead of her gloved hands. On 1/7/25 at 10:38 A.M., the Administrator provided a form titled, "Glove and Hand Washing Procedures", dated 2017 and indicated the policy was the one currently used by the facility. The policy indicated "...7. Gloves are changed any time hand washing would be required. This includes when leaving the kitchen for a break, or to go to another location in the building; after handling potentially hazardous raw food; or if the gloves become contaminated by touching the face, hair, uniform, other non-food contact surface, such as door handles and equipment...." 2. On 1/5/25 at 1:02 P.M., the meal cart arrived to the ICF/Maple unit with approximately 5 trays. The Dietary Manager had accompanied the cart to the unit. A tray was taken from the cart and the following temperatures of the food, were recorded: Italian Sausage - 116 degrees Pasta - 149 degrees Fruit punch drink - 56 degrees After the Dietary Manager checked the temperatures, the sausage was tasted and was not palatable for consumption, as it tasted uncooked. During an interview, on 1/5/25 at 1:07 P.M., the Dietary Manager indicated the sausage had not maintained a proper temperature and the punch was too warm, as it should be served cold. The		services weekly x 4 weeks, then one meal service weekly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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	Dietary Manager indicated the kitchen only had 10 plate warmers and there were more residents who ate in their rooms than the facility had plate warmers for use. The facility had 5 resident units in the facility. On 1/6/25 at 9:25 A.M., the Administrator provided a form titled, "Resource: Minimum Cooking Food Temperatures and Holding Times", dated 2017, and indicated the policy was the one currently used by the facility. The policy indicated Pork or Beef minimum temperature was 145 degrees. "...8. Meals that are served on room trays may be periodically checked at the point of service for palatable food temperatures. Food temperatures of hot foods on room trays at the point of service are preferred to be a 120 degrees or greater to promote palatability for the resident...." This citation relates to Complaints IN00450476, IN00450474, IN00449158 and IN00448896. 3.1-21(a)(2)			