STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155221	A. BUILDING 00 B. WING	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE HEALTH & REHAB	1120 E DAVIS DR TERRE HAUTE, IN 47802

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: January 4, 5, 6, 9, 10, 12, 13, 17, and 18, 2023 Facility number: 000126 Provider number: 155221 AIM number: 100266400 Census Bed Type: SNF/NF: 51 Residential: 24 Total: 75 Census Payor Type: Medicare: 8 Medicaid: 27 Other: 16 Total: 51 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 30, 2023.	F 0000	***Westminster Village Terre Haute wishes to have this submitted plan of correction (POC) stand as its allegation of compliance. Preparation and/or execution of this POC does not constitute admission to, nor agreement with either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.***	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of			

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

Shannon Williams | Administrator | 02/13/2023

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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	this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review, the facility failed to ensure residents were provided showers as preferred for 1 of 24 residents reviewed for choices (Resident 100). Finding includes: During an interview, on 1/5/23 at 2:01 p.m., Resident 100's wife indicated, her husband had not had a shower since Sunday, 1/1/23. The resident took showers daily and sometimes two showers a day, morning and evening, prior to his admission into the facility, when he was at home. Resident 100's record was reviewed on 1/13/23 at 10:31 a.m. The resident was admitted to the	F 0561	- Resident #100 discharged on January 9, 2023 - An audit has been completed to ensure showers are provided according to resident preference with no concerns identified. - Staff has been re-educated on providing showers in accordance with resident preference - The Director of Nursing or designee will conduct an audit to ensure showers have been provided according to resident preference 5 times a week for 4	02/27/2023

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	facility, on 12/30/22, with diagnoses included, but not limited to, heart failure, acute and chronic respiratory failure (difficulty breathing), chronic obstructive pulmonary disease (COPD-chronic condition involving constriction of the airways and difficulty or discomfort in breathing). An admission Minimum Data Set (MDS) assessment, dated 1/5/23, indicated the resident had a moderate cognitive impairment, it was very important for the resident to choose between a tub bath, shower, bed bath, or sponge bath; was an extensive assistance of two persons for bed mobility, transfers, dressing and was an extensive assistance of one person for toilet use and personal hygiene, and was total dependence of one staff for bathing. A care plan, dated 1/5/23, indicated the resident would have self-directed care, with interventions included, but not limited to, involve family in preferences as needed and assess for changes. A profile care guide indicated the resident was scheduled for showers on Tuesdays and Fridays. The medical record lacked documentation of refusal of showers. During an interview, on 1/12/23 at 10:20 a.m., the Director of Nursing (DON) indicated Resident 100 was scheduled for two showers a week, on Tuesday and Fridays, but he had only received two showers, on Sunday 1/1/23 and Friday 1/6/23, since his admission to the facility on 12/30/22. The DON provided the two shower sheet documents, dated 1/1/23 and 1/6/23. On 1/12/23 at 1:30 p.m., the DON provided and identified a document as a current facility policy,		weeks, weekly for 4 weeks and monthly for 4 months. Results of audits will be forwarded to the QA&A Committee for review and disposition - Date of Compliance: February 27, 2023	

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	titled "Resident Self Determination and Participation," dated February 2021. The policy indicated, "...Policy Statement...Our facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life...Policy Interpretation and Implementation...1. Each resident is allowed to choose activities, and schedule health care and healthcare providers, that are consistent with his or her interests, values, assessments, and plans of care, including: ...a. daily routine, such as sleeping and waking, eating, exercise and bathing schedules...." 3.1-3(u)(3)			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at			

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	the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).			

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	(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on record review and interview, the facility failed to ensure documented evidence of notification to the receiving hospital prior to the transfer of a resident for evaluation and treatment for 1 of 4 residents reviewed for hospitalization (Residents 9). Finding includes: Resident 9's record was reviewed on 1/13/23 at 2:32 p.m. An annual Minimum Data Set (MDS) assessment, dated 12/2/22, indicated the resident had a severe cognitive impairment. Diagnoses on the resident's profile included, but	F 0622	- Resident #9 readmitted on November 28, 2022 and has had no further transfers to the hospital for evaluation and treatment - An audit was completed to identify residents transferred to the hospital for evaluation and treatment with no issues identified - Licensed nurses have been re-educated regarding notification to the receiving hospital prior to the transfer of a resident for evaluation and treatment - The Director of Nursing or	02/27/2023

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	was not limited to, chronic obstructive pulmonary disease (COPD-a chronic condition involving constriction of the airways and difficulty or discomfort in breathing) and respiratory failure. Census information indicated Resident 9 had been discharged to the hospital on 11/22/22 and returned to the facility on 11/27/22. A progress note, dated 11/22/22 at 5:45 a.m., indicated Resident 9 kept calling out for her mom. The nurse had witnessed the resident attempting to transfer self out of the bed and stated that she wanted to get up. Staff assisted the resident up in her wheelchair and into the dining room. The nurse checked the resident's oxygen level and found that it read 66% (low oxygen level). The physician was called and ordered to send the resident to the hospital emergency department. The record lacked documentation the facility had contacted the receiving hospital to provide information related to the resident's transfer for evaluation and treatment. During an interview, on 1/17/23 at 11:10 a.m., the interim Director of Nursing (DON) indicated she was unable to find any documentation a report was called to the hospital at the time of the resident's hospital transfer on 11/22/22. On 1/17/23 at 11:15 a.m., the DON provided and identified a document as current facility policy titled, "Transfer or Discharge, Emergency," dated September 2012, which indicated, "...Policy Statement...Our facility shall make an emergency transfer or discharge when it is in the best interest of the resident...Policy Interpretation and Implementation...1. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility		designee will conduct an audit to ensure notification to the receiving hospital prior to transfer occurred 5 times a week for 4 weeks, weekly for 4 weeks and monthly for 4 months. Results of audits will be forwarded to the QA&A Committee for review and disposition - Date of Compliance: February 27, 2023	

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	will implement the following procedures: ...b. Notify the receiving facility that the transfer is being made...." 3.1-12(a)(3)			
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)			

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	(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or 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			

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	mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the 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 ensure transfer/discharge documents were developed and provided for hospital transfers for 2 of 4 residents reviewed for hospitalization (Resident 48 and 9), and notification of the transfer/discharge was provided to the Ombudsman for 1 of 4 residents reviewed for hospitalization (Resident 9). Findings include: 1. Resident 48's closed record was reviewed on	F 0623	- Resident #48 discharged on December 28, 2022 Resident #9 readmitted on November 28, 2022, and has had no further transfers to the hospital for evaluation and treatment. - An audit was completed to ensure transfer/discharge documents were developed and provided for hospital transfers and notification of the transfer/discharge was provided to the Ombudsman with no concerns	02/27/2023

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	1/17/23 at 9:28 a.m. The profile indicated the resident had been admitted to the facility for diagnoses which included, but were not limited to, chronic obstructive pulmonary disease (COPD-a chronic condition involving constriction of the airways and difficulty or discomfort in breathing), heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's need for blood), and was positive for COVID-19. A discharge, return not anticipated Minimum Data Set (MDS) assessment, dated 12/28/22, indicated the resident had an unplanned discharge to an acute care hospital. A progress note, dated 12/28/22 at 5:11 p.m., indicated the resident's oxygen (O2) saturation (a measure of how much hemoglobin [a red protein responsible for transporting oxygen in the] is currently bound to oxygen compared to how much hemoglobin remains unbound) had dropped into the low 80's on 5 liters (L) of supplemental O2 (Treatment in which a storage tank of oxygen or a machine called a compressor is used to give oxygen to people with breathing problems). The nurse applied a CPAP (continuous positive airway pressure-a method of respiratory therapy in which air is pumped into the lungs through the nose or nose and mouth during spontaneous breathing). 911 was called and the resident was sent to the emergency room (ER) for evaluation and treatment. The record lacked documentation of transfer/discharge form having been completed. During an interview, on 1/17/23 at 10:10 a.m., the Social Services Director (SSD) indicated she nor the medical records department were unable to		identified - The Interdisciplinary Team and licensed nurses have been re-educated regarding ensuring transfer/discharge documents are developed and provided to the hospital for transfers and that notification of the transfer/discharge is provided to the Ombudsman - The Administrator or designee will conduct an audit to ensure transfer/discharge documents were developed and provided for hospital transfers and notification of the transfer/discharge was provided to the Ombudsman 5 times a week for 4 weeks, weekly for 4 weeks and monthly for 4 weeks. Results of audits will be forwarded to the QA&A Committee for review and disposition - Date of Compliance: February 27, 2023	

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	find any transfer/discharge paperwork related to the resident's transfer to the hospital on 12/28/22. 2. Resident 9's record was reviewed on 1/13/23 at 2:32 p.m. An annual Minimum Data Set (MDS) assessment, dated 12/2/22, indicated the resident had a severe cognitive impairment. Diagnoses on the resident's profile included, but was not limited to, chronic obstructive pulmonary disease (COPD-chronic condition involving constriction of the airways and difficulty or discomfort in breathing) and respiratory failure (difficulty breathing). Census information indicated Resident 9 had been discharged to the hospital on 11/15/22 and returned to the facility on 11/19/22 and the resident had been discharged to the hospital on 11/22/22 and returned to the facility on 11/27/22. A progress note, dated 11/15/22 at 11:38 a.m., indicated staff had reported to the physician Resident 9 had right and left upper lung lobe wheezing and diminished lung sounds from the nurse assessment. The physician ordered to send the resident to the hospital emergency department. The family was notified. The note lacked documentation a Notice of Transfer or Discharge documentation was provided to the resident or resident representative and lacked documentation the representative of the Office of the State Long-Term Care Ombudsman was notified of the discharge to the hospital. A progress note, dated 11/15/22 at 4:00 p.m., indicated Resident 9's Power of Attorney (POA)/resident representative had called and gave an update of the resident had been admitted into the hospital.			

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	A progress note, dated 11/19/2022 at 4:37 p.m., indicated the resident had arrived at 3:45 p.m. per the facility transport to the facility from the hospital. The note lacked documentation a Notice of Transfer or Discharge had been provided to the resident or resident representative and lacked documentation the representative of the Office of the State Long-Term Care Ombudsman was notified of the discharge to the hospital. A progress note, dated 11/22/22 at 5:45 a.m., indicated Resident 9 kept calling out for her mom. The nurse had witnessed the resident attempting to transfer self out of the bed and stated that she wanted to get up. Staff assisted the resident up in her wheelchair and into the dining room. The nurse checked the resident's oxygen level and found that it read 66% (low oxygen level). The physician was called and ordered to send the resident to the hospital emergency department. 911 was called. The record lacked documentation a transfer/discharge form had been provided to the resident and lacked documentation the representative of the Office of the State Long-Term Care Ombudsman was notified of the discharge to the hospital. A progress note, dated 11/28/2022 at 2:37 p.m., indicated the resident had returned to the facility from the hospital. The note lacked documentation a Notice of Transfer or Discharge had been provided to the resident or resident representative and lacked documentation the representative of the Office of the State Long-Term Care Ombudsman was notified of the discharge to the hospital. On 1/17/23 at 10:18 a.m., the Social Services Director (SSD) indicated, she sent the discharge notifications to the ombudsman monthly, but was			

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	155221	A. BUILDING 00 B. WING	01/18/2023

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	unable to find documentation the representative of the Office of the State Long-Term Care Ombudsman was notified of Resident 9's transfers to the hospital on 11/15/22 and 11/22/22. During an interview, on 1/17/23 at 11:10 a.m., the interim Director of Nursing (DON) indicated she was unable to find any documentation the Notice of Transfer or Discharge was provided to the resident or resident representative at the time of the hospital transfer on 11/22/22. The documentation should have been sent to the hospital with the resident and the representative of the Office of the State Long-Term Care Ombudsman's office should have been notified of the discharges to the hospital. The facility did not have a policy for the representative of the Office of the State Long-Term Care Ombudsman notification and followed the State regulations. On 1/17/23 at 11:15 a.m., the DON provided and identified a document as current facility policy, titled "Transfer or Discharge, Emergency," dated September 2012, which indicated, "...Policy Statement...Our facility shall make an emergency transfer or discharge when it is in the best interest of the resident...Policy Interpretation and Implementation...1. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: ...d. Prepare a transfer form to send with the resident...." 3.1-12(a)(8)(D) 3.1-12(a)(9)(A) 3.1-12(a)(9)(B) 3.1-12(a)(9)(C) 3.1-12(a)(9)(D) 3.1-12(a)(9)(E)			

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	3.1-12(a)(9)(F) 3.1-12(a)(9)(G)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on record review and interview, the facility failed to ensure a bed hold policy was provided to a resident with a hospitalization for 1 of 4 residents reviewed for hospitalizations (Resident	F 0625	- Resident #9 readmitted on November 28, 2022, and has had no further transfers to the hospital for evaluation and treatment. - An audit was completed to	02/27/2023

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	9). Finding includes: Resident 9's record was reviewed on 1/13/23 at 2:32 p.m. An annual Minimum Data Set (MDS) assessment, dated 12/2/22, indicated the resident had a severe cognitive impairment. Diagnoses on the resident's profile included, but was not limited to, chronic obstructive pulmonary disease (COPD-chronic condition involving constriction of the airways and difficulty or discomfort in breathing) and respiratory failure (difficulty breathing). Census information indicated Resident 9 had been discharged to the hospital on 11/15/22 and returned to the facility on 11/19/22 and the resident had been discharged to the hospital on 11/22/22 and returned to the facility on 11/27/22. A progress note, dated 11/15/22 at 11:38 a.m., indicated staff had reported to the physician Resident 9 had right and left upper lung lobe wheezing and diminished lung sounds from the nurse assessment. The physician ordered to send the resident to the hospital emergency department. The family was notified. The note lacked documentation a bed hold policy was provided to the resident or resident representative. A progress note, dated 11/15/22 at 4:00 p.m., indicated Resident 9's Power of Attorney (POA)/resident representative had called and gave an update of the resident had been admitted into the hospital. A progress note, dated 11/19/2022 at 4:37 p.m.,		ensure a bed hold policy was provided to a resident with hospitalization with issues addressed. - The Interdisciplinary team and licensed nurses have been re-educated regarding ensuring a bed hold policy is provided to a resident with hospitalization. - The Administrator or designee will conduct an audit to ensure bed hold policy was provided 5 times a week for 4 weeks, weekly for 4 weeks and monthly for 4 months. Results of audits will be forwarded to the QA&A Committee for review and disposition - Date of Compliance: February 27, 2023	

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	indicated the resident had arrived at 3:45 p.m. per the facility transport to the facility from the hospital. The note lacked documentation a Notice of Transfer or Discharge had been provided to the resident or resident representative and lacked documentation the representative of the Office of the State Long-Term Care Ombudsman was notified of the discharge to the hospital. A progress note, dated 11/22/22 at 5:45 a.m., indicated Resident 9 kept calling out for her mom. The nurse had witnessed the resident attempting to transfer self out of the bed and stated that she wanted to get up. Staff assisted the resident up in her wheelchair and into the dining room. The nurse checked the resident's oxygen level and found that it read 66% (low oxygen level). The physician was called and ordered to send the resident to the hospital emergency department. 911 was called. The record lacked documentation a bed hold policy was provided to the resident or resident representative. During an interview, on 1/17/23 at 1:15 p.m., the interim Director of Nursing (DON) indicated the bed hold policy should have been given to the resident at the time of the transfer to the hospital. The DON provided and identified a document as a current facility policy, titled "BED-HOLD POLICY," dated 8/31/17. The policy indicated, "...POLICY: When a resident of the nursing facility is hospitalized or goes on a therapeutic leave, the facility will hold a bed for the resident's readmission as described in this policy. The facility will readmit the resident when the resident meets the criteria outlined in federal regulation governing the rights of nursing facility residents to be readmitted after a leave of absence...BED-HOLD NOTIFICATIONS: Each resident admitted receives information about			

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	bed-hold rights and completes a Bed-Hold Request form which also acknowledges receipt of policy. A second contact occurs at the time of hospital transfer (or just before therapeutic leave begins) to confirm the initial request. This second notification is documented on the original request form and is attached to information accompanying the resident. If bed-hold wishes change during a leave of absence, it is the responsibility of the resident or resident's representative to promptly inform the facility...BED-HOLD FOR MEDICARE RESIDENTS: Medicare does not pay to hold a health facility bed while a resident is on hospital leave, so a Medicare resident is 'discharged' upon hospitalization and the bed is released unless the resident or resident's responsible party elects to pay the bed-hold rate to hold the bed...." 3.1-12(a)(25) 3.1-12(a)(26)			
F 0641 SS=C Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the accuracy of Minimum Data Set (MDS) assessments for 4 of 18 residents' MDS assessments reviewed (Residents 18, 5, 14, and 8). Findings include: 1. Resident 18's record was reviewed on 1/6/23 at 3:03 p.m. The profile indicated the resident's diagnoses included, but were not limited to, delusional disorder (a type of mental health condition in which a person can't tell what's real from what's imagined) and major depressive	F 0641	· The Minimum Data Set (MDS) assessments for Resident #5, #8, #14 and #18 have been corrected and resubmitted - An audit of MDS section N and section A1500 of was completed to ensure the accuracy with no issues identified - The MDS Coordinator has been re-educated regarding coding accuracy of MDS section N, anticoagulants, antipsychotics and section A1500 PASRR - The Director of Nursing or	02/27/2023

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	disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). A physician's order, dated 8/25/22, indicated olanzapine (antipsychotic medication used to manage symptoms of mental health conditions such as: seeing, hearing, feeling, or believing things that others do not), 2.5 milligram (mg), by mouth at bedtime. A physician's order, dated 8/26/22, indicated olanzapine 5 mg by mouth one time daily. The December 2022 medication administration record (MAR) indicated the physician's orders for the olanzapine had been administered as ordered. Section N0410: Medications Received, of the quarterly MDS assessment, dated 12/29/22, indicated the resident had received antipsychotic medications, during the 7-day look back period (the time period over which the resident's condition or status is captured by the MDS assessment). Section N0450: Antipsychotic Medication Review, of the quarterly MDS assessment, dated 12/29/22, indicated antipsychotic medication were not received by the resident during the 7-day look back period. During an interview, on 1/9/23 at 10:27 a.m., the MDS Coordinator indicated the antipsychotic medication review section of the quarterly MDS had been coded incorrectly. She must have hit the wrong button when coding the antipsychotic medication review section. On 1/9/23 at 10:47 a.m., the MDS Coordinator provided a document, dated October 2018, titled,		designee will conduct an audit of section N and A1500 for accuracy weekly for 4 weeks and monthly for 5 months. Results of audits will be forwarded to the QA&A Committee for review and disposition - Date of Compliance: February 27, 2023	

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	"CMS's (Center for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual," and indicated it was the policy currently being used by the facility. The policy indicated, "...N0450: Antipsychotic Medication Review...Coding Instructions...Code 0, no: if antipsychotics were not received...Code 1, yes: if antipsychotics were received on a routine basis only...." 2. Resident 5's record was reviewed on 1/10/23 at 2:34 p.m. The profile indicated the resident's diagnoses included, but were not limited to, displaced supracondylar fracture (a fracture in the upper arm just above the elbow joint) and unspecified of the shaft of the tibia (fracture of the shaft of the shinbone). A quarterly Minimum Data Set (MDS) assessment, dated 12/29/22, indicated the resident received an anticoagulant (AC) medication (a substance that is used to prevent and treat blood clots in blood vessels and the heart; also known as a blood thinner) during the 7-day look back period (the time period over which the resident's condition or status is captured by the MDS assessment). The December 2022, medication administration record (MAR) lacked documentation of the resident ever having been administered an AC medication. A historical review of the resident's physician's orders indicated the resident had been admitted on Lovenox (an AC medication) on 9/22/22. The medication had been discontinued on 10/5/22. During an interview, on 1/13/23 at 3:14 p.m., the MDS Coordinator indicated she was unsure why			

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	the MDS assessment had been coded incorrectly. On 1/17/23 at 11:08 a.m., the MDS Coordinator provided a document, dated October 2018, titled, "CMS's (Center for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual," and indicated it was the policy currently being used by the facility. The policy indicated, "...N0410. Medications Received: Indicate the number of days the resident received the following medications...if not received during the last 7 days or since admission/entry or reentry if less than 7 days. Enter '0' if medication was not received by the resident during the last 7 days...." 3. Resident 14's record was reviewed on 1/13/23 at 9:10 a.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus (an impairment in the way the body regulates and uses sugar (glucose) as a fuel) with chronic foot ulcerations (an open sore or wound that occurs in approximately 15 percent of patients with diabetes and is commonly located on the bottom of the foot). A quarterly Minimum Data Set (MDS) assessment, dated 12/2/22, indicated the resident received an anticoagulant (AC) medication (a substance that is used to prevent and treat blood clots in blood vessels and the heart; also known as a blood thinner) during the 7-day look back period (the time period over which the resident's condition or status is captured by the MDS assessment). The November 2022 December 2022, medication administration record (MAR) lacked documentation of the resident ever having been administered an AC medication.			

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	A historical review of the resident's physician's orders lacked documentation of the resident ever having an order for an AC medication. During an interview, on 1/13/23 at 3:14 p.m., the MDS Coordinator indicated she was unsure why the MDS assessment had been coded incorrectly. On 1/17/23 at 11:08 a.m., the MDS Coordinator provided a document, dated October 2018, titled, "CMS's (Center for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual," and indicated it was the policy currently being used by the facility. The policy indicated, "...N0410. Medications Received: Indicate the number of days the resident received the following medications...if not received during the last 7 days or since admission/entry or reentry if less than 7 days. Enter '0' if medication was not received by the resident during the last 7 days...." 4. On 1/5/23 at 1:37 p.m., Resident 8's record was reviewed. Diagnoses included, but were not limited to, anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), schizophrenia (chronic, severe mental disorder that affects the way a person thinks, acts, expresses emotions, perceives reality), and schizoaffective disorder (chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions). A care plan, Problem, date initiated on 4/27/22 and revised on 11/18/22, indicated a Preadmission Screening and Resident Review (PASRR) Level II indicated Resident 8 had a mental illness, did not require specialized services. PASRR			

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	recommendations included continued mental health services, medication review, medication adjustment, medication monitoring, and medication administration with the goal of the resident would receive mental health services, medication review, medication adjustment, medication monitoring, and medication administration as needed through next review or 90 days. A care plan, Problem, date initiated 4/26/22 and revised on 7/18/22, indicated Resident 8 required the use of antipsychotic medications for the diagnosis of schizoaffective disorder, evident by excessive, crying, allegations, paranoia, obsessive behaviors, severe irritability. Resident 8 was a PASRR level II and was mentally ill. Interventions on the care plan included, but were not limited to, assist Resident 8 to reduce present level of anxiety by providing reassurance and comfort, with the goal of the resident would demonstrate decreased psychotic symptoms as evidenced by a reduction in physiological, emotional, and/or cognitive manifestations of psychosis, delusions or hallucinations through the next 90 days. Documentation, titled, "Notice of PASRR LEVEL I Screen Outcome PASRR Level II Onsite Evaluation Required," dated 12/29/21, indicated, "...[Resident 8's name]...Your health care professional and Ascend Management Innovations (Ascend) completed a Preadmission Screening and Resident Review (PASRR) Level I screen for you. This screen shows that you need a face-to-face Level II evaluation. PASRR Level I screens and Level II evaluations are require by Federal law, 42 U.S.C. 1396r(e)(7)...You need this PASRR Level II evaluation because you may have serious mental illness or an intellectual/developmental disability. The purpose			

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	of this evaluation is to decide whether a nursing facility is able to meet your needs. A clinician working for Community Mental Health Center (CMHC) will complete the Level II evaluation with you on behalf of Division of Aging...." Documentation, titled, "STATE OF INDICATION CERTIFICATION OF PASARR/MI preadmission Screening Determination," dated 1/7/23, indicated, "...Level II Mental Health Determination The Applicant/Resident...is mentally ill...does not require specialized services...Services of less intensity than specialized services: ...Continue Current MH [Mental Health] Services...Medication Review...Medication Adjustment...Medication Monitoring...Medication Administration...." An Annual Minimum Data Set Assessment (MDS), dated 12/30/22, Section A (1500) indicated, "No," Resident 8 had not been evaluated by PASRR Level II and determined to have a serious mental illness and/or mental retardation or related condition. During an interview, on 1/9/23 at 9:45 a.m., the Social Services Director (SSD) indicated, Resident 8 did have a Level II completed, on 1/7/22, which indicated PASRR determination of Long-Term Approval without specialized services. On 1/9/23 at 10:02 a.m., the MDS Coordinator indicated, Resident 8's MDS Assessment was incorrect and the resident did have a PASARR Level II, completed on 1/7/22. The MDS Coordinator provided a copy of Section A of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, was identified as a facility policy and procedure was provided by the MDS			

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	Coordinator 1. The manual indicated, "...Section A1500: Preadmission Screening and Resident Review (PASRR)...Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness...." 3.1-31(d)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure nail care was provided to a dependent resident for 1 of 24 residents reviewed for activities of daily living (ADL) (daily tasks related to resident care and hygiene) (Resident 2). Finding includes: On 1/4/23 at 12:25 p.m., Resident 2 was observed, with long, untrimmed fingernails with dark debris underneath the fingernails on bilateral (both) hands, while lying in bed, feeding himself lunch from a bedside table. On 1/5/23 at 11:50 a.m., Resident 2 was observed with long, untrimmed fingernails with dark debris underneath the fingernails on both hands, while lying in bed watching television. On 1/6/23 at 3:11 p.m., Resident 2 was observed in his room lying in bed with long, untrimmed fingernails with dark debris underneath the fingernails on both of his hands.	F 0677	- Nail care has been provided to Resident #2 - An audit was completed of dependent residents to ensure nail care was provided with no issues identified - Staff has been re-educated regarding the provision of nail care - The Director of Nursing or designee will conduct an audit to ensure nail care has been provided 5 times a week for 4 weeks, weekly for 4 weeks and monthly for 4 months. Results of audits will be forwarded to the QA&A Committee for review and disposition - Date of Compliance: February 27, 2023	02/27/2023

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	Resident 2's clinical record was reviewed on 1/10/23 at 1:15 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 11/9/22, indicated the resident had a moderate cognitive impairment, required extensive assistance of two person for bed mobility, transfers, and toilet use, extensive assistance of one person for personal hygiene, total dependence of two persons for bathing, and supervision with set up help only for eating. Diagnoses included, but were not limited to, transient cerebral ischemic attack (a mini stroke caused by a temporary disruption in the blood supply to part of the brain) and hypertension (high blood pressure), and undifferentiated schizophrenia (mental disorder characterized by continuous or relapsing episodes of psychosis). A care plan, dated 11/18/22, indicated the resident had a self-care deficit with bed mobility, dressing, grooming, feeding, toileting, transfers, and locomotion on/off the unit with interventions included, but not limited to, encourage the resident to do as much for self as able in ADL (activities of daily living) areas daily to maintain current level of self-performance. Review of Resident 2's clinical record for December 2022 and January 2023 lacked documentation the resident had refused nail care. On 1/12/23 at 10:42 a.m., the Director of Nursing (DON) provided Resident 2's shower schedule and shower sheets, which included nail care, for December 2022 and January 2023. The DON indicated Resident 2 was on the shower schedule for three showers a week and nail care should have been provided with each shower. Nail care was not documented as completed during the			

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	December showers and was only documented on 1/8/23 for the January 2023 showers. On 1/12/23 at 11:30 a.m., DON provided and identified a document as a current facility policy, titled "Fingernails/Toenails, Care of," dated February 2018. The policy indicated, "...Purpose...The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections...General Guidelines...1. Nail care includes cleaning/trimming on shower days and as needed...." 3.1-38(a)(3)(E)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to assess and treat a Resident's two pressure ulcers present upon admission into the facility for 1 of 1 resident reviewed for pressure ulcers (Resident 100).	F 0686	- Resident #100 discharged on January 9, 2023 - An audit was completed to ensure that residents with pressure ulcers present upon admission have been assessed and receiving treatment with no	02/27/2023

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	Finding includes: During an interview, on 1/5/21 at 10:02 a.m., Resident 100 indicated he had been admitted to the facility from another facility, on 12/30/22, with two pressure ulcers on his bottom. The other facility had changed the dressings. Resident 100's record was reviewed on 1/13/23 at 10:31 a.m. The resident was admitted to the facility, on 12/30/22, with diagnoses included, but not limited to, heart failure, acute and chronic respiratory failure (difficulty breathing), chronic obstructive pulmonary disease (COPD-chronic condition involving constriction of the airways and difficulty or discomfort in breathing). A Clinical Admission Assessment, dated 12/30/22 at 4:32 p.m., indicated the resident did not have any pressure ulcers upon admission to the facility. A physician order, dated 12/30/22, indicated pressure reducing chair cushion and pressure reducing mattress to bed. A nursing progress note, dated 1/1/23 at 2:36 p.m., indicated during a shower a CNA (Certified Nursing Assistant) noticed a dressing on the resident's coccyx (buttocks). The dressing was from the previous facility. The resident's wife stated the previous facility was changing the dressing every other day on the coccyx. Resident 100 had a 2 cm (centimeter) by 2 cm open area with red edges and white in the center, with two pin size holes on each side of the wound, the one on the left side was a little bigger and deeper, and bleeding. Notified wound nurse and order for Medi honey and cover with allevyn dressing daily.		issues identified. - License nurses have been re-educated on completing a skin assessment upon admission and ensuring appropriate treatment is in place - The Assistant Director of Nursing or designee will conduct an audit to ensure a skin assessment has been completed on new admissions and treatment ordered 5 times a week for 4 weeks, weekly for 4 weeks and monthly for 4 months. Results of audits will be forwarded to the QA&A Committee for review and disposition - Date of Compliance: February 27, 2023	

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	A physician order, dated 1/1/23, indicated to clean and apply med honey to open areas on the coccyx and cover with allevyn dressing daily. A skin/wound progress note, dated 1/4/23 at 10:23 a.m., indicated while assessing the resident's skin and wounds to verify measurements, resident was noted to have a fluid-filled blister on the right heel. Resident to float heels while in bed (Heel Up pillow provided), has low air loss mattress. The wound doctor was notified, and new order was received to apply med honey and wrap with kerlix daily. A physician order, dated 1/4/23, indicated to cleanse area of right heel with normal saline and apply skin prep wipe every evening shift. A care plan, initiated on 1/4/23, indicated the resident had a pressure ulcer to the left buttock with interventions included, but not limited to, evaluate skin condition on a daily basis during care and report abnormalities to the physician and treatments and medications as ordered. A care plan, initiated on 1/4/23, indicated the resident had a pressure ulcer to the right buttock with interventions included, but not limited to, evaluate skin condition on a daily basis during care and report abnormalities to the physician and treatments and medications as ordered. A care plan, initiated on 1/4/23, indicated the resident had a pressure ulcer to the right heel with interventions included, but not limited to, evaluate skin condition on a daily basis during care and report abnormalities to the physician and treatments and medications as ordered. A nursing progress note, dated 1/5/23 at 3:52 p.m.,			

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	indicated wound doctor completed virtual visit with resident. Resident noted with wound to left buttock, right buttock, right heel, and left 1st toe. Family at bedside aware of wound doctor to follow. -Left buttock noted as stage II (Partial-thickness loss of skin with exposed dermis where the wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister) with measurements of 1.5 centemeter (cm) by (x) 2.5 cm. Wound bed pink/red with slight serous drainage noted. There was no odor and Periwound was pink and intact. -Right buttock noted as unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar) with measurements of 4.0 cm x 2.5 cm. Wound bed was covered with adherent yellow slough, no drainage noted on dressing, no odor noted, and the periwound was red and intact. -Right heel presents as intact fluid filled blister, stage II with current measurements of 5 cm x 3.3 cm. No drainage noted. A 5-day admission Minimum Data Set (MDS) assessment, dated 1/5/23, indicated the resident had a moderate cognitive impairment; was very important for the resident to choose between a tub bath, shower, bed bath, or sponge bath; was an extensive assistance of two persons for bed mobility, transfers, dressing and was an extensive assistance of one person for toilet use and personal hygiene, and was total dependence of one staff for bathing; and the resident had two pressure ulcers upon admission and had acquired a pressure ulcer since admission to the facility. During an interview, on 1/9/23 at 10:50 a.m., the Assistant Director of Nursing (ADON)/wound			

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	nurse indicated a skin evaluation should have been completed at the time of the resident's admission and a skin evaluation should been completed with every new found skin issue, but ADON indicated she had just started as the wound nurse and had not completed the evaluations for Resident 100's pressure ulcers. On 1/9/23 at 12:30 p.m., the Administrator (ADM) provided and identified a document as a current facility policy, titled "Prevention of Pressure Injuries," dated April 2020. The policy indicated, "...Purpose...The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors...Risk Assessment...1. Assess the resident on admission (within eight hours) for existing pressure injury risk factors...Skin Assessment...1. Conduct a comprehensive skin assessment up (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior discharge...." 3.1-40(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates			

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	that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure a Resident, who had experienced significant weight loss, received a physician and registered dietician ordered health shake supplement for 1 of 1 resident reviewed for weight loss (Resident 9). Finding includes: Resident 9's record was reviewed on 1/13/23 at 2:32 p.m. A quarterly Minimum Data Set Assessment (MDS), dated 12/22/22, indicated the resident had a severe cognitive impairment; impaired hearing; required extensive assistance of one staff for eating, bed mobility, transfers, locomotion, dressing, person hygiene, toilet use, and bathing; weight loss, and had two hospitalizations. Diagnoses on the resident's profile included, but was not limited to, Non-Alzheimer's dementia (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), chronic obstructive pulmonary disease (COPD-chronic condition involving constriction of the airways and difficulty or discomfort in breathing), respiratory failure (difficulty breathing), pneumonia (infection that inflames air sacs in one or both lungs and fill with fluid), encephalopathy (disorder of the brain	F 0692	- Resident #9 has been receiving ordered health shakes as ordered. - An audit was completed of residents who have experienced significant weight loss and are receiving ordered health shake supplements with no issues identified. - Licensed nurses and QMAs have been re-educated on providing ordered health shakes for residents experiencing significant weight loss - The Director of Nursing or designee will conduct an audit to ensure ordered health shakes are provided 5 times a week for 4 weeks, weekly for 4 weeks and monthly for 4 months. Results of audits will be forwarded to the QA&A Committee for review and disposition - Date of Compliance: February 27, 2023	02/27/2023

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	that can be caused by disease or injury), and dysphagia-oral phase (difficulty swallowing). Census information indicated Resident 9 had been discharged to the hospital on 11/15/22 and returned to the facility on 11/19/22 and the resident had been discharged to the hospital on 11/22/22 and returned to the facility on 11/27/22. A Nutrition/Dietary Note, dated 12/20/2022 at 4:43 p.m., indicated Resident 9 had experienced a significant weight loss of 14% and weighed 126.4 pounds, down 14% in a month and the resident was underweight. The resident intakes a mechanical soft diet and nectar thickened liquids (NTL), due to dysphagia. Continue the current diet and offer health shake at 240cc's (cubic centimeters) BID (twice a day). An active physician's order, dated 12/20/22 at 10:00 p.m., indicated to offer health shake two times a day. A care plan, date initiated on 4/1/22 and revised on 12/20/22, indicated the resident was at risk for weight loss, interventions included, but were not limited to, Offer the mechanical soft diet along with NTL (cold beverages only) and a two-handled cup with a lid for hot beverages. Offer health shake at 240cc's BID. The December 2022 nor the January 2023 Medication Administration Record (MAR) included the administration of the health shake twice a day. The medical record lacked documentation the health shake was administered. During an interview, on 1/17/23 at 11:52 a.m., the interim Director of Nursing (DON) indicated she was unable to find a flow sheet with documented			

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	consumption of the health shake nor the December and January MAR flow sheets associated with the order showed the health shake was given to the resident starting on 12/20/22. She was pretty sure the resident had received the health shake but could not find any documentation. Staff should have documented the consumption of the health shake in the resident's medical record. Today, she had added to the January MAR to offer the health shake twice a day. On 1/17/23 at 11:55 a.m., the DON provided and identified a document as a current facility policy, titled "Medication and Treatment Orders," dated April 2014. The policy indicated, "...Policy Statement...Orders for medications and treatments will be consistent with principles of safe and effective order...Policy Interpretation and Implementation...1. Medications shall be administered only upon the written order of person duly licensed and authorized to prescribe such medications in the state...." 3.1-46(1)(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure physician's orders were followed related to monitoring a resident's daily weight and the assessment of his fistula as ordered for 1 of 1	F 0698	- Physicians orders for Resident #29 for monitoring weight and assessment of fistula for dialysis are being followed - An audit was completed of	02/27/2023

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	resident reviewed for dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), (Resident 29). Findings include: Resident 29's record was reviewed on 1/10/23 at 9:53 a.m. The profile indicated the resident's diagnoses included, but were not limited to, end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). An annual Minimum Data Set (MDS) assessment, dated 5/11/22, indicated the resident required dialysis services. A care plan, dated 5/19/22 and revised on 11/18/22, indicated the resident received hemodialysis (a treatment to filter wastes and water from your blood) through a fistula (a connection that's made between an artery and a vein for dialysis access) in his right arm, on Monday, Wednesday, and Friday. Interventions included, but were not limited to, notify physician of any significant changes and weigh resident prior to dialysis and after dialysis. Physician's orders dated October 2022 through January 8, 2023 were reviewed. The orders included, but were not limited to: A physician's order, dated 3/29/22, indicated daily weights on day shift. Notify the physician of 3-pound weight gain in 24 hours, or 5-pound weight gain in 1 week.		residents on dialysis to ensure weight and assessment of fistula orders are being followed with no issues identified - Nursing staff has been re-educated regarding following physician orders for monitoring of weight and assessing fistulas for residents on dialysis - The Director of Nursing or designee will conduct an audit to ensure weight monitoring and fistula assessments for residents on dialysis are being followed as ordered 5 times a week for 4 weeks, weekly for 4 weeks and monthly for 4 months. Results of audits will be forwarded to the QA&A Committee for review and disposition - Date of Compliance: February 27, 2023	

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	Review of the October 2022 treatment administration record (TAR) lacked documentation of the resident's weight being taken, per physician's order, 12 of 31 days for the month, (10/10/22, 10/12/22, 10/13/22, 10/15/22, 10/17/22, 10/19/22, 10/20/22, 10/21/22, 10/22/22, 10/23/22, 10/24/22, and 10/25/22). The record lacked documentation of any resident refusal. Review of the November 2022 TAR lacked documentation of the resident's weight being taken, per physician's order, 18 of 30 days for the month, (11/3/22, 11/4/22, 11/5/22, 11/9/22, 11/10/22, 11/11/22, 11/12/22, 11/13/22, 11/14/22, 11/15/22, 11/17/22, 11/18/22, 11/19/22, 11/20/22, 11/22/22, 11/23/22, 11/24/22, and 11/26/22). The record lacked documentation of any resident refusal. Review of the December 2022 TAR lacked documentation of the resident's weight being taken, per physician's order, 15 of 31 days for the month, (12/1/22, 12/2/22, 12/3/22, 12/4/22, 12/7/22, 12/8/22, 12/11/22, 12/12/22, 12/13/22, 12/14/22, 12/24/22, 12/25/22, 12/26/22, 12/29/22, and 12/30/22). The record lacked documentation of any resident refusal. Review of the January 1, through January 8, 2023, TAR lacked documentation of the resident's weight being taken, per physician's order, 4 of 8 days, (1/1/23, 1/2/23, 1/3/23, and 1/5/23). The record lacked documentation of any resident refusal. b. A physician's order, dated 7/22/22, indicated check for positive bruit and thrill (the rumbling or swooshing sound of a dialysis fistula bruit is caused by the high-pressure flow of blood through the fistula) in the right upper arm every shift. If absent notify physician.			

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	Review of the October 2022 treatment administration record (TAR) lacked documentation that the resident's fistula bruit and thrill had been assessed, per physician's order, 10 of 31 days on days shift, (10/10/22, 10/12/22, 10/13/22, 10/17/22, 10/19/22, 10/20/22, 10/23/22, 10/24/22, 10/25/22, and 10/28/22), and 10 of 31 day on evening shift, (10/12/22, 10/14/22, 10/18/22, 10/19/22, 10/20/22, 10/24/22, 10/25/22, 10/29/22, 10/30/22, and 10/31/22). The record lacked documentation of any resident refusal. Review of the November 2022 TAR lacked documentation that the resident's fistula bruit and thrill had been assessed, per physician's order, 10 of 30 days on day shift, (11/3/22, 11/4/22, 11/9/22, 11/11/22, 11/13/22, 11/17/22, 11/18/22, 11/19/22, 11/23/22, and 11/24/22), and 6 of 30 days on evening shift, (11/3/22, 11/9/22, 11/10/22, 11/12/22, 11/17/22, and 11/19/22). The record lacked documentation of any resident refusal. Review of the December 2022 TAR lacked documentation that the resident's fistula bruit and thrill had been assessed, per physician's order, 4 of 31 days on day shift, (12/3/22, 12/14/22, 12/24/22, and 12/26/22), and 5 of 31 days on evening shift, (12/1/22, 12/4/22, 12/8/22, 12/23/22, and 12/26/22). The record lacked documentation of any resident refusal. Review of the January 1, through January 8, 2023, TAR lacked documentation the resident's fistula bruit and thrill had been assessed, per physician's order, 3 of 8 days on day shift, (1/1/23, 1/2/23, and 1/3/23), and 2 of 8 days on the evening shift, (1/1/23 and 1/5/23). The record lacked documentation of any resident refusal.			

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	During an interview, on 1/10/23 at 11:10 a.m., the Administrator (ADM) indicated she believed the resident likely had refused to have his weights taken or his fistula assessed, as he had a tendency to do that. Even so, she understood if he had refused, the refusals should have been documented. During an interview, on 1/10/23 at 11:41 a.m., the Director of Nursing (DON) indicated there was not a specific policy for treatment administration, but there was one for medication administration. The medication administration policy would also pertain to following and documenting treatment orders. She could only assume that the treatments had either been completed, but not documented or that they were missed altogether. On 1/10/23 at 11:15 a.m., the DON provided a document, with a revised dated of December 2012, titled, "Administering Medications," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Interpretation and Implementation...3. Medications must be administered in accordance with the orders...19. The individual administering...must initial the resident's MAR (medication administration record) on the appropriate line...." 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-			

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	§483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure documentation of the administration of medications for 1 of 5 residents reviewed for unnecessary medications (Resident 18). Findings include: Resident 18's record was reviewed on 1/6/23 at 3:03 p.m. The profile indicated the resident diagnoses included, but were not limited to, hyperlipidemia (known as high cholesterol, when there are too many lipids [fats] in the blood), gastro-esophageal reflux disease (GERD-when stomach acid repeatedly flows back into the tube connecting your mouth and stomach [esophagus]), and restless leg syndrome (causes unpleasant or uncomfortable sensations in the legs and an irresistible urge to move them). Review of the resident's December 2022 and	F 0757	- Resident #18's Atorvastatin, Pepcid and Ropinirole is being given - An audit was completed of the administrations of medications with issues addressed as needed - Licensed nurses and QMAs have been re-educated regarding the documentation of the administration of medications - The Director of Nursing or designee will conduct an audit to ensure documentation of administration of medications 5 times a week for 4 weeks, weekly for 4 weeks and monthly for 4 months. Results of audits will be forwarded to the QA&A Committee for review and disposition - Date of Compliance: February 27, 2023	02/27/2023

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	January 2023 medication administration records (MARs) indicated the following: a. A physician's order, dated 3/29/22, indicated atorvastatin calcium tablet (a medication used to lower cholesterol) 40 milligrams (mg), by mouth at bedtime. The December 2022 MAR lacked documentation of the medication having been administered on the evening shifts of 12/3/22 and 12/28/22. The January 2023 MAR lacked documentation of the medication having been administered on the evening shift of 1/3/23. The record lacked documentation of resident refusal. b. A physician's order, dated 10/14/22, indicated Pepcid (famotadine) tablet (a medication to decrease the production of stomach acid) 40 mg by mouth at bedtime. The December 2022 MAR lacked documentation of the medication having been administered on the evening shifts of 12/3/22 and 12/28/22. The January 2023 MAR lacked documentation of the medication having been administered on the evening shift of 1/3/23. The record lacked documentation of resident refusal. c. A physician's order, dated 3/29/22, indicated ropinirole HCL tablet (medication used to treat restless legs syndrome) 0.5 mg, by mouth at bedtime. The December 2022 MAR lacked documentation of the medication having been administered on the evening shifts of 12/3/22 and 12/28/22. The January 2023 MAR lacked documentation of the medication having been administered on the evening shift of 1/3/23. The record lacked documentation of resident refusal. During an interview, on 1/9/23 at 11:41 a.m., the Director of Nursing (DON) indicated she was pretty certain the medications had been given, but just not signed off. It was the nurse's			

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	responsibility to document in the MAR when a medication had been administered. On 1/9/23 at 12:36 p.m., the Administrator (ADM) provided a document, with a revised date of April 2007, titled, "Documentation of Medication Administration," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Interpretation and Implementation: 1. A nurse or certified medication aide...shall document all medications administered to each resident on the resident's medication administration record (MAR). 2. Administration of medication must be documented immediately after (never before) it is given...." 3.1-48(a)(3)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;			

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	§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure documented physician rationale for a declination of a gradual dose reduction (GDR) of a psychotropic medication (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) and documentation of the administration of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications (Resident 18).	F 0758	- Documented physician rationale for the declination of a gradual dose reduction of a psychotropic medication has been completed for Resident #18 Documentation of the administration of psychotropic medications has been completed for Resident #18 - An audit was completed of documented physician rationale	02/27/2023

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	Findings include: Resident 18's record was reviewed on 1/6/23 at 3:03 p.m. The profile indicated the resident's diagnoses included, but were not limited to, delusional disorders (a type of mental health condition in which a person can't tell what's real from what's imagined), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and abnormal weight loss. An admission Minimum Data Set (MDS) assessment, dated 3/1/22, indicated the resident had a mood severity score (also known as PHQ-9. A questionnaire to assist in determination of depression severity) and received medications which included, but were not limited to, antipsychotics (medications used to treat symptoms of psychosis, such as delusions), antianxiety medications (medication to treat anxiety symptoms), and antidepressants (used to treat depressive symptoms). A care plan, dated 4/1/22, and revised on 8/24/22, indicated the resident's received antidepressant, antianxiety, and antipsychotic medications. Interventions included, but were not limited to, administer medications as ordered and pharmacy and physician to consider dosage reduction when clinically appropriate. a. A pharmacy recommendation, dated 8/11/22, recommended to evaluate the benefit and add justification for continuation of current dose for an order for Remeron (used to treat depression and can be used as an appetite stimulant) 7.5 milligrams (mg) at bedtime for appetite. The physician documented continue current treatment.		for declining gradual dose reduction psychotropic medications with no issues identified An audit of documentation of the administration of psychotropic medications has been completed with issues addressed - The physician and psychiatric nurse practitioner have been re-educated on documentation of rationale for declining a recommended gradual dose reduction Licensed nurses and QMAs have been re-educated regarding documentation of the administration of psychotropic medications - The Director of Nursing or designee will conduct an audit of gradual dose reduction recommendations to ensure documented physician rationale is present for declinations monthly for six months. The Director of Nursing or designee will conduct an audit to ensure documentation of administration of medications 5 times a week for 4 weeks, weekly for 4 weeks and monthly for 4 months. Results of audits will be forwarded to the QA&A Committee for review and disposition	

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	The record lacked documentation to justify the physician's decision to continue the treatment. During an interview, on 1/9/23 at 9:48 a.m. the Director of Nursing (DON) indicated no other documentation to justify how the physician's had made the decision to continue the mediation had been found. She was unsure as to the physician's reasoning behind his decision. On 1/9/23 at 12:36 p.m., the Administrator (ADM) provided a document, with a revised date of May 2019, titled, "Medication Regimen Reviews," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Interpretation and Implementation...12. The attending physician's documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it...15. Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record...." b. Review of the resident's December 2022 and January 2023 medication administration records (MARs) indicated the following: A physician's order, dated 8/25/22, indicated olanzapine tablet (antipsychotic medication) 2.5 milligrams (mg), by mouth at bedtime. The December 2022 MAR lacked documentation of the medication having been administered on the evening shifts of 12/3/22 and 12/28/22. The January 2023 MAR lacked documentation of the medication having been administered on the evening shift of 1/3/23. The record lacked documentation of resident refusal. A physician's order dated 3/29/22, indicated Remeron tablet (antidepressant medication) 15 mg,		- Date of Compliance: February 27, 2023	

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	by mouth at bedtime. The December 2022 MAR lacked documentation of the medication having been administered on the evening shifts of 12/3/22 and 12/28/22. The January 2023 MAR lacked documentation of the medication having been administered on the evening shift of 1/3/23. The record lacked documentation of resident refusal. A physician's order, dated 3/29/22, indicated Xanax tablet (antianxiety medication) 0.25 mg, by mouth two times daily. The December 2022 MAR lacked documentation of the medication having been administered on the evening shifts of 12/3/22 and 12/28/22. The record lacked documentation of resident refusal. During an interview, on 1/9/23 at 11:41 a.m., the Director of Nursing (DON) indicated she was pretty certain the medications had been given, but just not signed off. It was the nurse's responsibility to document in the MAR when a medication had been administered. On 1/9/23 at 12:36 p.m., the Administrator (ADM) provided a document, with a revised date of April 2007, titled, "Documentation of Medication Administration," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Interpretation and Implementation: 1. A nurse or certified medication aide...shall document all medications administered to each resident on the resident's medication administration record (MAR). 2. Administration of medication must be documented immediately after (never before) it is given...." 3.1-48(b)(1)			
F 9999				

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Bldg. 00	3.1-14 PERSONNEL (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education if applicable. (5) Professional licensure, certification, or registration number or dining assistant certificate or letter of completion if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with the facility's policy. (10) Date and reason for separation. (r) The employee's personnel record shall be retained for at least three (3) years following termination or separation of the employee from employment. (s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction	F 9999	- #16 is no longer employed at Westminster Village Terre Haute - An audit of newly hires employees was completed with no issues RN identified. - The HR Director was re-educated regarding required tuberculosis testing for newly hired employees. - The Executive Director or designee will conduct an audit to ensure two-step tuberculin skin testing for newly hired employees has been completed 5 times a week for 4 weeks, weekly for 4 weeks and monthly for 4 months. Results of audits will be forwarded to the QA&A Committee for review and disposition - Date of Compliance: February 27, 2023	02/27/2023

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	can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination; and (B) reports of all employment-related health examinations. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and			

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	dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure a newly hired employee received a two-step tuberculin (TB) skin test (one method of determining whether a person is infected with Mycobacterium tuberculosis), at the time of employment, for 1 of 10 employee records reviewed. Findings include: During a review of the Employee Records document (State Form 5440), on 1/17/23 at 10:17 a.m., the form lacked documentation of a completed two-step TB skin test for Registered Nurse (RN) 16. During an interview, on 1/18/23 at 8:48 a.m., the Administrator (ADM) provided a document of a single TB skin test for RN 16, dated 7/13/22. The employee record document indicated RN 16 had been hired by the facility on 10/27/22. The ADM indicated that was the TB skin test document the employee had provided when hired. At the time RN 16 had been hired, the facility was out of TB skin test solution and had required RN 16 to complete a TB Questionnaire. They were not able to find the completed TB questionnaire for RN 16. On 1/18/23 at 9:20 a.m., the Interim Director of Nursing (IDON) provided a document, with a revised date of July 2010, titled, "Tuberculosis,			

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	Employee Screening for," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Interpretation and Implementation: 1. Each newly hired employee will be screened for TB infection and disease after employment offer has been made but prior to the employee's duty assignment...Tuberculin Skin Testing...2. The initial TB testing will be a two-step TST...."			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: January 4, 5, 6, 9, 10, 12, 13, 17, and 18, 2023 Facility number: 000126 Residential Census: 24 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 30, 2023.	R 0000	***Westminster Village Terre Haute wishes to have this submitted plan of correction (POC) stand as its allegation of compliance. Preparation and/or execution of this POC does not constitute admission to, nor agreement with either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.***	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of			

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	155221	A. BUILDING 00 B. WING	01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE HEALTH & REHAB	1120 E DAVIS DR TERRE HAUTE, IN 47802

(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
	the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure scheduled staff were certified in first aid (help given to a sick or injured person until full medical treatment is available) were present on site at all times, for 9 of 21 shifts reviewed for staff with cardio-pulmonary resuscitation (CPR-a lifesaving technique that's useful in many emergencies, such as a heart attack or near drowning, in which someone's breathing or heartbeat has stopped) and first aid. Findings include: On 1/18/23 at 2:25 p.m., the residential care area staffing schedules, dated 12/30/22 through 1/13/23, were reviewed. The schedules indicated the facility ran three shifts on the schedule. First shift covered 6:00 a.m., to 2:30 p.m., second shift covered 2:00 p.m., to 10:30 p.m., and third shift covered 10:00 p.m., to 6:30 a.m. CPR and first aid certification cards were reviewed	R 0117	·No residents suffered any untoward effects from scheduled staff lacking first aid certification ·An audit of staff records was completed and issues identified have been corrected ·Scheduled staff have been certified in CPR and first aid ·The AL Clinical Supervisor or designee will conduct an audit to ensure scheduled staff are certified in CPR and first aid 5 times a week for 4 weeks, weekly for 4 weeks and monthly for 4 months. Results of the audits will be forwarded to the QA&A Committee for review and disposition.	03/06/2023

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	and compared to the staffing schedules. The certification cards review indicated all shifts had staff present who were CPR certified, but only 3 staff had the additional first aid certification. The schedules lacked documentation of staff certified in first aide as follows: a. The schedules lacked documentation of staff on duty with first aid certification for 12 of 21 day shifts, (12/31/22, 1/1/23, 1/2/23, 1/4/23, 1/5/23, 1/7/23, 1/8/23, 1/9/23, 1/10/23, 1/11/23, 1/12/23, and 1/13/23). One shift was partially covered from 6:00 a.m., to 10:30 a.m., on 1/3/23. b. The schedules lacked documentation of staff on duty with first aid certification for 9 of 21 evening shifts, (12/30/22, 12/31/22, 1/2/23, 1/3/23, 1/4/23, 1/9/23, 1/11/23, 1/12/23, and 1/13/23). c. The schedules lacked documentation of staff on duty with first aid certification for 3 of 21 night shifts, (12/31/22, 1/6/23, and 1/10/23). During an interview, on 1/18/23 at 3:00 p.m., the Administrator (ADM) indicated she was not aware that when CPR training was provided that first aid training was not automatically part of the certification. It would be the policy of the facility, that all staff would be certified in both CPR and first aid, and all shifts be fully covered, as required by the regulation.			
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction			

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	can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	Based on record review and interview, the facility failed to ensure a newly hired employee received a two-step tuberculin (TB) skin test (one method of	R 0121	- QMA #17 is employed at Westminster Village Terre Haute and her TB is now current - An audit of newly hires	02/27/2023

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	determining whether a person is infected with Mycobacterium tuberculosis), at the time of employment, for 1 of 5 employee records reviewed. Findings include: During a review of the Residential Care Employee Records document (State Form 53877), on 1/17/23 at 11:20 a.m., the form lacked documentation of a completed two-step TB skin test for Qualified Medication Aide (QMA) 17. During an interview, on 1/18/23 at 8:48 a.m., the Administrator (ADM) indicated QMA 17 had been hired on 6/21/22. At that time, the facility was out of TB solution and had required all staff to complete a TB Questionnaire. She indicated she was not able to find a completed TB questionnaire for QMA 17. On 1/18/23 at 9:20 a.m., the Interim Director of Nursing (IDON) provided a document, with a revised date of July 2010, titled, "Tuberculosis, Employee Screening for," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy Interpretation and Implementation: 1. Each newly hired employee will be screened for TB infection and disease after employment offer has been made but prior to the employee's duty assignment...Tuberculin Skin Testing...2. The initial TB testing will be a two-step TST...."		employees was completed with no issues identified. - The HR Director was re-educated regarding required tuberculosis testing for newly hired employees. - The Executive Director or designee will conduct an audit to ensure two-step tuberculin skin testing for newly hired employees has been completed 5 times a week for 4 weeks, weekly for 4 weeks and monthly for 4 months. Results of audits will be forwarded to the QA&A Committee for review and disposition	