STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155692	A. BUILDING 00 B. WING	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE POINTE OF HUNTINGTON	1180 WEST 500 NORTH HUNTINGTON, IN 46750

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: December 26, 27, 30, 31, 2024 and January 2 and 3, 2025. Facility number: 002910 Provider number: 155692 AIM number: 200345390 Census Bed Type: SNF/NF:58 SNF: 13 Residential: 50 Total: 121 Census Payor Type: Medicare: 15 Medicaid: 24 Private: 32 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 14, 2025.	F 0000		
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to provide daily grooming assistance for 1 of 3 residents reviewed for Activities of Daily Living (ADLs). (Resident 3) Findings include:	F 0677	Nail care for resident 3 was completed on 12/31/24. The DON or designee will complete an audit on fingernails of all residents to determine if any other resident lacked receiving	01/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jodie Stanley	Health Facility Administrator	01/30/2025

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	During a random observation, on 12/26/24 at 12:40 p.m., Resident 3 was sitting in a wheelchair in front of her television. Her fingernails were long and had a brown substance under the tips. Resident 3 indicated staff normally kept up on her nails, but they had been busy lately. During an interview, on 12/27/24 at 9:50 a.m., Resident 3 indicated she had received a shower yesterday. Resident 3's fingernails were observed to be long and had a brown substance under the tips. During an interview, on 12/30/24 at 9:51 a.m., Resident 3 indicated she would get a shower that night and she wanted her nails cut. Her nails remained long and had a brown substance underneath the tips. Resident 3's clinical record was reviewed on 12/30/24 at 10:01 a.m. Diagnoses included major depressive disorder, bipolar disorder, chronic kidney disease stage 3, emphysema, dyspnea, and borderline intellectual functioning. An annual Minimum Data Set (MDS) assessment, dated 9/29/24, indicated Resident 3 was cognitively intact. No behaviors were identified during the assessment period. She required partial/ moderate assistance of staff for showering/bathing self, upper and lower body dressing and personal hygiene. Rejection of care was not present during the assessment period. The Point of Care notes for nail care indicated Resident 3 had accepted complete nail care (clean, cut, and file) on 12/2/24, 12/9/24, 12/16/24, 12/23/24, and 12/30/24.		proper nail care. Nail care for any residents noted to be lacking nail care will be provided immediately. Education and in-service on the facility policy for nail care will be completed with all direct care staff. The DON or designee will conduct a random audit of nail care on at least five (5) residents per week for the next 4 weeks. The DON and facility administrator will review the audits on a weekly basis. If 100% compliance is achieved in the initial 4 weeks, a bi-weekly audit of five (5) resident's fingernails will be completed for two months or until 100% substantial compliance is achieved. Results of the bi-weekly audits will be reviewed by the DON and facility administrator bi-weekly. Once the nail audit shows 100% compliance for 3 consecutive months, the summary of findings will be presented to the Quality Assurance Committee for review. If the QA Committee determines that 100% compliance was achieved on a consistent basis, the audits will end.	

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	During an interview, on 12/31/24 at 8:39 a.m., Resident 3 indicated she had asked staff to cut her nails the night before. Her nails remained long and had a brown substance underneath the tips. During an interview, on 12/31/24 at 8:47 a.m., CNA 10 indicated activities staff trimmed residents' nails once a week. During an interview, on 12/31/24 at 8:48 a.m., Activities Staff 45 indicated the nurse, or the CNAs trimmed the residents' nails. During an interview, on 12/31/24 at 9:00 a.m., CNA 12 indicated the nurse trimmed Resident 3's nails on shower days. During an interview, on 12/31/24 at 9:04 a.m., the ADON indicated the facility did monthly nail checks on all the residents. If a resident refused nail care, it would be documented in the progress notes. Nail care meant the nails would be cleaned, but not necessarily cut. She indicated she would speak with Resident 3 about receiving nail care. During an interview, on 12/31/24 at 1:40 p.m., the DON indicated CNAs trimmed non-diabetic residents' nails on their shower days. It would be documented under their point of care charting tab. During a random observation, on 1/2/25 at 2:26 p.m., Resident 3's nails were short and had a brown substance underneath the tips. During an interview, on 1/2/25 at 1:59 p.m., CNA 14 indicated Resident 3's nails were not that long and didn't feel they were too dirty. She did not try to cut the residents' nails as the resident liked them mid-length but did clean them. Nails should be trimmed on the first shower day of the week.			

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	During an interview, on 1/2/25 at 2:05 p.m., CNA 15 indicated she cleaned Resident 3's nails during her shower. The resident's nails were mid-length, but not that dirty. It was normal for Resident 3 to have her nails clean and by the next morning have debris under her nails. Resident 3 didn't normally ask for her nails to be trimmed. A current facility policy, provided by the Administrator on 1/2/25 at 2:10 p.m. and titled "Activities of Daily Living," indicated "... A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene ...." 3.1-38(3)(E)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview and record review, the facility failed to provide supervision to prevent repeated falls for 1 of 3 residents reviewed for falls. (Resident 30) Findings include: Resident 30's clinical record was reviewed on 12/30/24 at 9:11 a.m. Diagnoses included Alzheimer's disease with late onset, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, essential hypertension, and anxiety disorder. Current physician orders, on 12/30/24, included amlodipine besylate (anti-hypertensive) 2.5	F 0689	An updated fall risk assessment will be completed for resident #30. Care plans related to fall prevention will be reviewed and updated to reflect appropriate interventions for the resident. Revisions to the fall interventions to be provided to the direct caregivers of resident #30. An audit will be completed to identify any resident that has sustained a fall in the past 30 days. Fall risk assessments and care plans for these identified residents will be reviewed to ensure assessments are up to date and that fall interventions in place are appropriate for the	01/31/2025

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	milligram (mg), Celexa (antidepressant) 10 mg, buspirone (antianxiety) 10 mg, and Rozerem (sedative) 8 mg. Ordered fall interventions included the following: non-skid strips next to bed, chair and toilet, red non-slip placemat to bedside table, touch pad call light, leave bathroom light on at night, Dycem (anti-slip mat) to recliner, bed height marked at 24 inches top of mattress per therapy, keep walker within reach at all times, Every one hour safety checks, stop sign to bathroom door (keep door shut with sign up, do not leave on toilet unsupervised, keep call light on left side when in bed, door chime to bathroom door, concave mattress, offer bedtime snack, call light wrapped in glow in the dark tape, floor mat at bathroom side of bed, weighted blanket while in bed, encourage to sit in lounge during the day, bed against well, and frequent verbal cues to utilize call light. A quarterly Minimum Data Set (MDS) indicated Resident 30 was moderately cognitively impaired. She had no impairment on her upper and lower extremities. She needed moderate assistance from staff for upper and lower body dressing, and toileting. She required substantial/ maximal assistance from staff for personal hygiene. She required supervision or touching assistance from staff for sit-to-stand transfers, toilet transfers and shower transfers. Resident 30 experienced two or more falls since the prior assessment. A care plan, initiated on 11/11/21 and revised on 10/28/24 , indicated Resident 30 would be free from falls with significant injury thru the next review. Interventions included: assess fall risk potential at admit, quarterly and with significant changes, assist with transfers, toileting, and ambulation as needed, bed against the wall, bed height marked at 24 inches top of mattress per		resident. All nursing staff will be in-serviced on the facility policy for Accidents and Supervision with an emphasis placed on why following fall interventions is necessary. Staff will be encouraged to provide input to interventions to prevent falls. Falls of residents are discussed each morning in the interdisciplinary stand-up meeting which is held on business days, Monday – Friday. Falls that occur on the weekend are discussed on Monday. Per the facility Fall Program policy, any resident that sustains a fall will be reviewed by the IDT team at least weekly to discuss the details of the fall, new interventions that were implemented and interventions that were discontinued due to no longer being deemed effective. A summary of falls will be presented each quarter to the Quality Assurance Committee. Residents identified in the summary as having frequent falls will be discussed during the QA committee meeting. The Quality Assurance Committee will look at current interventions for residents who frequently fall and present ideas on other interventions that could be tried. Monitoring of all falls and interventions will continue on an ongoing basis.	

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	therapy, call light cord wrapped in glow in the dark tape, concave mattress to bed, do not leave the resident on the toilet unsupervised, door chime to bathroom door, Dycem to recliner, encourage resident to sit in the lounge during the day, floor mat on bathroom side of bed, frequent verbal cues to utilize call light, keep call light and personal belongings within reach, keep call light on left side of bed when in bed, keep walker within reach at all times, leave bathroom light on at night, monitor blood pressure per order, monitor for medication side effects, monitor in fall risk meeting for four weeks after admit or fall, motion alarm sensor to the bathroom door, non-skid strips next to bed and chair and in front of the toilet, offer a bedtime snack, orient to room, bathroom and call light, Every one hour safety checks 3P's, red non-slip placemat on bedside table, restorative nursing program six times per week, stop sign to bathroom door, touch pad call light, vitamin D per orders and weighted blanket while in bed. A nursing progress note, dated 10/12/24 at 5:32 p.m., indicated Resident 30 was sitting on the floor directly in front of her recliner. She was sitting up on her buttocks with her legs bent up in front of her. The resident indicated she was going to the bathroom and lost her balance causing her to fall. Resident 30's walker was within reach; she was wearing socks and shoes. A head-to-toe assessment was completed. No injuries, redness, or bruising was noted due to the fall. The resident was assisted off the floor and into a standing position by two staff members. The resident denied any pain or discomfort and she was ambulating per her usual. A nursing progress note, dated 10/13/24 at 2:15 p.m., indicated Resident 30 had complaints of left wrist pain and was requesting Tylenol. Resident			

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	30's left wrist was slightly discolored and appeared to be turning into a bruise, although the discoloration wasn't quite purple in color. Her left wrist was slightly swollen. A suspected cause was from the resident being found on the floor around midnight last night. A new order was received for a left wrist x-ray. A nursing progress note, dated 10/14/24 at 3:21 a.m., indicated Resident 30 had a left distal radial fracture (a break in the radius bone near the wrist). A progress note, dated 10/14/24 at 9:51 a.m., indicated the nurse practitioner ordered that the resident be seen in the orthopedics' walk in clinic that day. A nursing progress note, dated 10/14/24 at 11:00 a.m., indicated Resident 30 returned for the orthopedic walk- in clinic with a cast placed on her left wrist. The resident was able to move all her fingers and thumb. She was to follow up with the orthopedics walk-in clinic in three weeks for x-rays and to ensure proper healing. A nursing progress note, dated 10/14/24 at 3:12 p.m., indicated Resident 30's code blue alarm was sounding. Resident 30 was sitting on her buttocks on the bathroom floor directly in front of the toilet. Staff were with the resident at the time of the fall and stated the resident left go of the railing and started to fall backwards. The staff member were able to lower the resident down to the floor. The resident did not hit her head. A head to toe assessment did not indicate injuries. A Morse Fall Scale report, dated 10/21/24, indicated Resident 30 was at a high risk of falling. A nursing progress note, dated 11/7/24 at 1:28			

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	p.m., indicated Resident 30 was found sitting on the floor on the far side of the bed. The resident stated she slid/ lowered herself to the floor. She was assessed for injuries and denied hitting her head. The resident was assisted off the floor by staff members and her bed was moved against the wall. A nursing progress note, dated 11/17/24 at 11:26 p.m., indicated Resident 30 was found sitting beside her bed on the protective floor mat. A walker was beside the resident. Resident 30 indicated she was not trying to go to the bathroom. The resident denied bumping her head or having any pain/ discomfort. The resident was assisted back to bed by staff members. No apparent physical injuries were noted after the resident was assessed for injuries. A Fall Risk Evaluation, dated 11/17/24, indicated Resident 30 had three or more falls in the past three months, intermittent confusion, she was ambulatory, had poor vision, balance problems with walking, and decreased muscular coordination. A nursing progress note, dated 11/30/24 at 7: 45 p.m., indicated Resident 30 was found on the floor in her bathroom. The resident's walker was in the bathroom with the resident. The resident was wearing her tennis shoes. She indicated she was trying to go to the bathroom and missed the toilet. No injuries were noted after assessing the resident. A nursing progress note, dated 12/5/24 at 10:29 p.m., indicated staff heard a crash and found Resident 30 sitting on the floor mat by her bed. The nurse assessed the resident for injuries. The resident denied hitting her head and denied any			

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	pain. The resident's left elbow was pink and had a superficial scratch without any drainage. The resident was assisted to her feet by staff members and ambulated to the restroom. A progress note, dated 12/9/24 at 11:37 a.m., indicated a Fall Risk sign was placed in the resident's room. Point of Care documentation for every hour safety checks for the month of December 2024 were not completed as ordered. During an interview, on 1/2/25 at 9:42 a.m., CNA 17 indicated Resident 30 was on fall interventions including multiple motion censors and every hour safety checks which included checking for pain, potty, and position. Documentation was under the task tab in the computer. During an interview, on 1/2/25 at 9:43 a.m., the ADON indicated Resident 30 had numerous fall interventions in place, including hourly safety checks. Those safety checks included making sure the resident's needs were met. Documentation was listed under the task tab on the computer. Staff members checked it off once they have completed the checks. It should be checked off every hour. During an interview, on 1/2/25 at 10:31 a.m., CNA 18 indicated Resident 30 was on hourly rounding. Hourly rounding documentation was listed under the task tab. During an interview, on 1/2/25 at 1:53 p.m., the Administrator indicated the CNAs generally charted at the end of their shift and it would take time to back time all of their rounding's throughout their shift.			

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	A current policy, titled "Fall Program", provided by the Administrator, on 1/2/25 at 2:10 p.m., indicated the following: " ...Interventions will be put in place based upon the assessment and as prevention for all new residents along with care plan review ...." 3.1-45(a)(2)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on observation, record review, and interview, the facility failed to ensure appropriate clinical indications for the use of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 2) Findings include: During an observation, on 12/26/24 at 12:42 p.m., Resident 2 sat in a recliner with her feet elevated. The television was on. During an observation, on 12/30/24 at 9:44 a.m., the resident sat in a recliner with her feet elevated. The television was on. During an observation, on 1/3/25 at 2:35 p.m., the resident sat in a recliner and looked at a book. Resident 2's record was reviewed on 12/30/24 at 10:24 a.m. Diagnoses included other recurrent depressive disorders, anxiety disorder, unspecified dementia, moderate with mood disturbance, unspecified dementia, moderate, with anxiety, and major depressive disorder, single episode, severe with psychotic features.	F 0758	The medication regimen for resident #2 was reviewed on 1/15/25 by the psych Nurse Practioner (NP) that follows this resident. The indication for the prescribed drug has been clearly documented by the NP in the medical record. The facility has identified that any resident receiving an antipsychotic medication has the potential to be affected if the medication is used unnecessarily. An audit will be completed by the Social Service Director and DON to identify other residents who have current orders for antipsychotic medications. The audit will also include determining if the prescribed antipsychotic medication is being used unnecessarily. If medications are identified as possibly being used unnecessarily, the attending physician or NP will be consulted to determine if the use of the medication is appropriate or a gradual dose reduction or	01/31/2025

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	Physician's orders included donepezil (for Alzheimer's) 10 milligrams (mg) - daily at bedtime (12/16/24), citalopram (antidepressant) 20 mg daily (5/2/24), risperidone (antipsychotic) 0.25 mg daily at bedtime (11/6/24), and tramadol (for pain) 50 mg two times a day (11/19/24). A 12/20/24 Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. The resident felt down, depressed, or hopeless two to six days of the assessment period. She sometimes felt lonely or isolated from those around her. The resident exhibited verbal behavioral symptoms directed toward others one to three days of the assessment period. The resident wandered one to three days of the assessment period. The wandering did not put the resident at significant risk at getting into a potentially dangerous place. The resident's current behavior status, care rejection, and wandering had worsened since the prior assessment completed on 11/6/24. The resident required partial/moderate assistance with eating, oral hygiene, toileting, showering /bathing self, upper and lower body dressing, putting on /taking off footwear, and personal hygiene. Resident 2's current care plan for anxiety indicated episodes of anxiety and was to be observed for repetitive questions or statements, irritability, shortness of breath, and difficulty finding words she desired to use in conversation (initiated 11/24/23 and revised 12/28/24). The interventions included allow the resident time to answer questions and to express her feelings and/or fears, play calming music or a television program of interest, and redirect to meaningful activities of potential interest or activities of preference (all initiated 11/24/23). A current care plan for depression indicated she		discontinuation of the medication should be considered. All Licensed Nursing staff will be in-serviced regarding the facility policy for Unnecessary Drugs. A copy of the facility policy on Unnecessary Drugs will be provided as a reference to the facility's rounding physician and psych NP. The DON and Social Service Staff will review any new orders for antipsychotic medication to ensure indication for use is appropriate and clearly documented in the medical records. The audit will be completed weekly for the next 4 consecutive weeks. Findings of the weekly audits will be shared with the facility administrator. If compliance is achieved at 100% in the initial 4 weeks, the audit will be completed for an additional two months. Findings of the monthly audits will be shared with the facility administrator. If the additional two months have 100% compliance, a summary of the audits will be presented to the Quality Assurance Committee for review. If the Quality Assurance Committee determine that there have been three consecutive months of antipsychotic medications only being prescribed when appropriate the monitoring will conclude.	

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	had stated she was experiencing episodes of depression and was to be observed for a decrease in socialization, a decrease in participation in activities of interest, irritability, and episodes of tearfulness. She had diagnoses of other recurrent depressive disorder and depressive disorder with psychotic features and took risperidone (initiated 11/24/23 and revised on 12/28/24). The interventions included allow the resident time to vent feelings and validate, encourage the resident to reminisce/share life stories, observe and report moods and behaviors, offer activities of preference or past enjoyment, and offer emotional support and reassurance (all initiated 11/24/23). A current care plan for resistance to care related to dementia indicated the resident could become verbally and physically combative with staff during care (initiated 12/26/24 and revised 12/28/24). Interventions included allow the resident to make choices, allow the resident to talk about feelings, assume a non-threatening posture: smile and talk with the resident in a pleasant, cheerful tone of voice, encourage as much participation/interaction by the resident as possible during care activities, establish a routine that is comfortable for the resident, maintain routine/minimize changes, give clear explanation of all care activities prior to and as they occur during each contact, give positive feedback, and if irritated, reapproach (all initiated 12/26/24). A current care plan for behaviors of getting up without assistance, not wanting/refusing assistance to use the bathroom, or using the walker indicated the resident could become irritated when staff attempted to assist the resident (initiated and revised 12/26/24). Interventions included anticipate and meet the resident's needs, assist the resident to a quiet			

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	155692	A. BUILDING 00 B. WING	01/03/2025

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	area, reduce noise and stimulation around her, consider psych evaluation if appropriate, encourage participation in activities of enjoyment or previous interest, evaluate antecedents, such as noise levels, time of day, being tired, etcetera, evaluate the resident for items such as a recent medication change, an infection, etcetera, explain all procedures to the resident before starting and allow the resident time to adjust to changes, if the resident continues to be agitated but safe, leave the area and reapproach later, offer opportunities for physical exercise, snacks/nutrition and fresh air, provide opportunity for positive interactions, attention, for example, stop and talk with the resident as passing by, provide positive feedback to the resident, and talk with the resident in a calm voice (all initiated 12/26/24). A current care plan for the potential to be physically aggressive indicated the resident had a history of being physically aggressive with staff (initiated and revised on 12/26/24). Interventions included one on one with the Social Services Director (SSD), administer medications as ordered and monitor/document for side effects and effectiveness, allow the resident time to express herself and her feelings about the situation, anticipate and meet the resident's needs, consider counseling if appropriate, encourage as much participation/interaction by the resident as possible during care activities, give the resident as many choices as possible about care and activities, identify potential antecedents to physical aggression, if the resident continues to be agitated but safe, leave the area and reapproach later, and when resident becomes agitated, intervene before agitation escalates: guide away from source of distress; engage calmly in conversation (all initiated 12/26/24).			

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	A current care plan for being verbally aggressive indicated the resident had a history of yelling and cursing at staff (initiated and revised on 12/26/24). Interventions included one on one with the SSD, observe and document behavior, including attempted interventions, provide positive feedback to the resident, and redirect/distract with activities of interest (all initiated 12/26/24). A 9/6/24 at 10:01 a.m. progress note by the psychological services Nurse Practitioner (NP), indicated the resident was seen to follow up on a request by the pharmacy to attempt a gradual dose reduction of her psychotropic (drugs that affect a person's mental state) medications. The risperidone was discontinued. A gradual dose reduction attempt for the citalopram, lorazepam (antianxiety), and trazodone (antidepressant) was clinically contraindicated due to the discontinuation trial of the risperidone. A Nurses' Note, dated 9/18/24 at 1:40 p.m., indicated the resident told the CNA she was cold. When the CNA explained, they were going to go to the bathroom and get some clothes on, the resident called her a "bitch." The room temperature was 73 degrees according to the room thermometer. A Nurses' Note, dated 9/21/24 at 11:08 a.m., indicated the resident had a knot and bruise on the right side of her upper forehead. The resident indicated she had hit her head on her bedside table when she fell asleep in her chair and denied pain or discomfort. Neurological checks were initiated. The medical provider was notified. A Nurses' Note, dated 9/25/24 at 11:30 p.m., indicated the resident kept getting out of bed by herself, would not leave her gown on, or leave or			

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	bed pad on her bed. She continued to transfer herself without her walker or wheelchair and did not use her call light. She urinated on the floor. A Nurses' Note, dated 9/25/24 at 11:41 p.m., indicated the resident was lying naked in her bed. Her hospital gown and bed pad were on the floor in her bathroom. She did not have a brief on. She indicated to the nurse she did not wear gowns at night, and she got them in the morning. The resident refused to put a gown on and got agitated. A Nurses' Note, dated 9/26/24 at 7:59 p.m., indicated the resident was in the hallway without clothes on. The resident was assisted to the bathroom, and morning care was given. The resident ambulated to the dining room with a scowl on her face. The resident yelled she wanted cold tea when asked if she would like hot tea. Iced tea was prepared. The resident yelled she wanted it in a mug. The resident refused to speak anymore. She fed herself in the dining room. A Progress Note, dated 9/26/24 at 11:40 a.m. by the psychological services NP, indicated the resident was seen to follow up on the recent discontinuation of the risperidone. The resident was visited in her room with no distress noted. Medications and behaviors were reviewed. The current psychiatric plan of care was continued. A Nurses' Note, dated 9/26/24 at 1:05 p.m., indicated the resident had removed all her clothing and refused to get dressed. She eventually agreed to get dressed. A Nurses' Note, dated 9/27/24 at 12:28 p.m., indicated the resident had a behavior and did not listen to suggestions to go to the recliner and rest.			

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	The resident did not want to take her UTI stat medication. She was encouraged to transfer and move but was not amenable. She seemed to understand, but did not seem to want to follow instructions. An assessment for stroke was performed, and no signs or symptoms of stroke were observed. The resident moved her tongue out of mouth involuntarily multiple times. A Nurses' Note, dated 9/27/24 at 5:55 p.m., indicated the resident did not act appropriately. She was found walking in the room with no clothes or shoes on. The resident was assisted with dressing and assisted to chair. She was found again with no shirt or shoes on. The resident indicated she did not want to be dressed because her back hurt. The resident declined to put hard sole shoes on but did accept slippers. A Nurses' Note, dated 9/28/24 at 1:07 a.m., indicated the resident got up from bed twice through the shift and walked beside her bed using the wheelchair as a walker. She told the staff she went to the bathroom, but no output was seen in the toilet bowl. A Nurses' Note, dated 9/28/24 at 7:22 a.m., indicated the resident was resting in bed and declined to get dressed and come down to breakfast. She complained of back pain. Acetaminophen (oral pain med) and trolamine salicylate (topical cream for pain) were administered. A Nurses' Note, dated 9/28/24 at 9:24 a.m., indicated the resident was up ambulating in her room completely dressed with her walker. She denied pain or urgency with urination. Her urine was clear amber color with no foul odor.			

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	A Nurses' Note, dated 9/28/24 at 11:26 a.m., indicated the resident had removed her clothing and sat in her chair. She refused to eat lunch in the dining room. A Nurses' Note, dated 9/28/24 at 1:12 p.m., indicated the resident wore a gown and sat in her recliner. She had a large bowel movement in her chair. A Nurses' Note, dated 9/28/24 at 1:41 p.m., indicated the primary care NP was notified. New orders were received for a stat urinalysis with a culture and sensitivity, vital signs every shift for 48 hours, initiate hypodermoclysis (administration of fluids into the subcutaneous tissue to provide hydration) to the abdomen of normal saline 1000 milliliters (ml) at 50 ml/hour and ceftriaxone (antibiotic) 1 gram intramuscularly on 9/28/24 and 9/29/24. A Nurses' Note, dated 9/29/24 at 5:04 a.m., indicated a urine specimen was collected and sent to the lab. A Nurses' Note, dated 9/29/24 at 9:42 a.m., indicated the urinalysis results indicated a culture was not indicated. The resident's morning care was completed without difficulty and she fed herself breakfast in her room. A Nurses' Note, dated 9/29/24 at 1:02 p.m., indicated the resident had no abnormal behaviors that shift. A Nurses' Note, dated 9/29/24 at 9:03 p.m., indicated the resident was found standing up using her walker without assistance twice. She was found once after taking herself to the toilet.			

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	A Nurses' Note, dated 9/30/24 at 9:49 a.m., indicated the psychological services NP was notified of the increase in behaviors. The NP indicated she would like the resident to be monitored for sleep patterns to ensure the resident was getting adequate sleep. A Nurses' Note, dated 9/29/24 at 10:23 p.m., indicated the resident was found on the floor in her room lying on her left side. Her gown was wet. A Nurses' Note, dated 9/30/24 at 12:11 p.m., indicated the resident refused to get up in the morning. She lay in bed until 11:00 a.m. She was incontinent of bowel and bladder and used the call light multiple times saying she did not get her medications. A Nurses' Note, dated 9/30/24 at 1:05 p.m., indicated the resident was thrusting her tongue out of her mouth constantly. A Nurses' Note, dated 9/30/24 at 7:06 p.m., indicated the resident was found lying in front of the window. The resident indicated she was trying to close the blinds for the evening and tripped on her call light cord. She hit her elbow on the air conditioning unit. A Nurses' Note, dated 9/30/24 at 10:13 p.m., indicated the resident was reminded to call for help. She was brought out to the lounge area to sit after supper. She was assisted to the bathroom and brought back out to the lounge. She asked to get ready for bed at 8:45 p.m. She was assisted with bedtime care, assisted to her recliner, and reminded to call when she was ready to go to bed. She was checked on at 9:30 p.m. She had transferred herself to her bed.			

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	A Nurses' Note, dated 10/1/24 at 5:03 p.m., indicated the resident was checked on throughout the night. The resident was awake each time. The resident indicated she had not slept at all. A Nurses' Note, dated 10/1/24 at 12:13 p.m., indicated the resident stated she was up all night. She had not been seen napping throughout the shift, which was a change, as the resident normally napped some throughout the day. A Nurses' Note, dated 10/1/24 at 11:30 p.m., indicated the resident was upset and wanted a bed pad on her bed, but wanted a white one not a blue one. She scooted to the bottom of the bed and curled up in a ball. She repeatedly said she needed a white bed pad on her pad. Staff attempted various things to help her, and resident refused. A Nurses' Note, dated 10/2/24 at 3:00 a.m., indicated the resident was found on the floor sitting by her room chair with her walker overturned. The resident had a bruise on her left foot. The resident indicated she was going to the bathroom when she fell. A Nurses' Note, dated 10/2/24 at 9:12 a.m., indicated the resident was in the hallway repeatedly stating she was ready for dinner and ready to go up. The resident became agitated with the foot pedals on her wheelchair, When the foot pedals were removed to get the wheelchair closer to the table the resident insisted on having foot pedals on and under her feet. The foot pedals were moved back. The resident continued to request the foot pedals be moved back and forth. She leaned forward as far as she could nearly falling several times. She repeatedly put her finger in her hot water in her tea cup and stated it was			

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	cold. The resident's brow was furrowed with facial grimacing. The hot water had steam. A Nurses' Note, dated 10/2/24 at 10:45 a.m., indicated the resident's neck and back were massaged with a topical menthol analgesic. The resident smacked her lips and fixated on a bracelet. A Nurses' Note, dated 10/2/24 at 11:34 a.m., indicated the psychological services NP was notified of the staff's report of the resident being restless and agitated. The resident sat at the table for lunch. The resident was smiling and talkative. She indicated she had fallen last night and was looking for her blanket. The resident had some difficulty finding her words and smacked her lips repeatedly throughout the conversation. A Nurses' Note, dated 10/2/24 at 12:33 p.m., indicated the psychological services NP gave a new order for risperidone 0.25 mg every bedtime for dementia with behavioral disturbance. A Nurses' Note, dated 10/3/24 at 9:55 p.m., indicated the resident refused morning care. She indicated it was only 5:15 a.m., and she would get up at 9:00 a.m. The resident was told it was 10:00 a.m. She yelled it was not. The resident had not been sleeping all morning. She had been awake and refused to get out of bed with all staff attempts. A Nurses' Note, dated 10/3/24 at 1:11 p.m., indicated the resident continued to lie in bed and refused morning care. She refused to go to the bathroom for toileting. She allowed the CNA to reposition her in bed twice during the shift. A Progress Note, by the psychological services			

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	NP, dated 10/4/24 at 11:06 a.m., indicated the resident was seen to follow up on a failed attempt to discontinue risperidone. The notable events were agitation and uncontrolled tongue thrusts. The staff reported that the resident experienced irritable moods and a worsening of symptoms of insomnia. The staff reported the resident had been hyper fixated on multiple issues. The resident was visited in the dining room with no distress noted. A Nurses' Note, dated 10/7/24 at 12:20 a.m., indicated the resident was restless and complained the room was too hot. She was offered a fan, and she said it would get too cold. She was assisted to the bathroom and a sheet was obtained for her to use instead of a blanket. A Nurses' Note, dated 10/7/24 at 6:21 a.m., indicated the resident was restless throughout the night and had the call light gripped in both hands. She turned on the call light frequently to let staff know she was awake, she was in bed, or she wished the staff would leave her alone so that she could get some sleep. A Nurses' Note, dated 11/1/24 at 4:32 p.m., indicated the resident tried to walk with a wheelchair. The CNA encouraged the resident to use her walker. A Nurses' Note, dated 12/4/24 at 4:05 p.m., indicated the resident continued to attempt to use a wheelchair as a walker. During an interview on 1/3/25 at 12:41 p.m., the SSD indicated the resident had been on the risperidone for a long time. She had a gradual dose reduction and experienced all kinds of behaviors. She provided pink behavior sheets filled out by the CNAs for the behaviors during			

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	the gradual dose reduction trial. A behavior sheet, dated 9/21, provided by the SSD on 1/3/25 at 12:41 p.m., indicated the resident had been denying the time, when she was told breakfast was over soon. She said she was not ready to get up. When the CNA left, the resident got herself dressed and started walking down to breakfast. The resident said the staff did not get her up or it was too late. She complained of not sleeping. A behavior sheet, dated 9/28/24 at 1:53 p.m., provided by the SSD on 1/3/25 at 12:41 p.m., indicated the resident refused to keep her clothes on and removed them three times. She removed her brief and had a trail of feces from her chair to the toilet. A behavior sheet, dated 9/29/24 at 8:00 p.m., provided by the SSD on 1/3/25 at 12:41 p.m., indicated the resident pushed her call button repeatedly. She was mean and aggressive. A behavior sheet, dated 9/30/24 at 9:00 p.m., provided by the SSD on 1/3/25 at 12:41 p.m., indicated the resident yelled at the CNA because the resident's wheelchair was not in the right place. When the CNA fixed the wheelchair location, the resident screamed at the CNA to get out. A behavior sheet, dated 9/30/24 at 4:00 p.m., provided by the SSD on 1/3/25 at 12:41 p.m., indicated the resident kept getting up on her own. She then fell. She wanted to get up on her own all the time. During an interview, on 1/3/25 at 2:20 p.m., the SSD indicated the resident had previously gone to			

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	a mental health center and had been diagnosed with other specified disruptive, impulse control, and conduct disorder. During an interview, on 1/3/24 at 2:35 p.m., CNA 7 indicated if any residents have any behaviors a pink behavior slip is filled out. She had not provided care often for the resident, but had not had any problems with her when she did provide care. She was uncertain where to look for the interventions to provide for a resident's care such as behaviors and falls but would speak to her supervisor to ensure she had the right answer. During an interview, on 1/3/25 at 2:38 p.m., RN 8 indicated the last time the resident's medication was changed, she had an increase in confusion. The resident had a lot of tongue movements too. RN 8 had performed multiple assessments on the resident checking for stroke and other possible causes for her change in behavior. The NP had been notified at that time. The resident was sometimes alert and oriented to person, place, and time. The resident was offered snacks and activities to help her mood. She had always been compliant taking her medications for RN 8. During an interview, on 1/3/25 at 2:45 p.m., CNA 7 indicated when they charted, they could see some of the interventions, but not all of them. She would check with the nurse to find out what the interventions were for the residents to make sure she was using all of them. During an interview, on 1/3/25 at 2:48 p.m., LPN 9 indicated she had been providing care for the resident for about a month. She had been trying to use her wheelchair instead of her walker for ambulation. She went to therapy, and they worked with her and got her a different walker. She did not			

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	use her wheelchair anymore. The psychological services NP had recently discontinued the resident's antianxiety medication and increased her pain medication. LPN 9 believed the resident was having more pain than anxiety. The change had helped her. The resident had no other behaviors of which she was aware. During an interview, on 1/3/25 at 3:13 p.m., CNA 7 indicated she was not sure what the resident's behaviors were other than trying to walk with her wheelchair instead of her walker. Her mood changes could also go into psychosis, she thought as the resident thought she was more capable than she really was. During an interview, on 1/3/25 at 3:16 p.m. LPN 9 indicated she believed the resident's psychosis was exhibited by her not being able to be redirected, and it was difficult to explain. For example, the resident insisted on using a wheelchair for walking instead of the walker because she believed therapy had told her to use the wheelchair for a walker. The resident did not hit or yell, she just argued. She had difficulty understanding concepts when she was experiencing her psychosis. During an interview, on 1/3/25 at 3:20 p.m., RN 8 indicated when she took care of the resident during her episodes of tongue movements and her ability to understand and comprehend was impaired that was when the resident was exhibiting her symptoms of psychosis. She believed the psychosis mimicked a stroke. During an interview, on 1/3/25 at 3:24 p.m., the SSD indicated for the resident's psychosis the staff told her the resident can be very delusional. The staff told her a couple of months ago the			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident was not making sense. She thought the resident's psychosis presented as the resident told the staff one day her resident representative took her remote control. The SSD found the remote and did not put a progress note in. The resident representative had taken the remote to the staff and asked them to turn on happy shows and not sad as he believed sad shows worked her up. Another example was when the resident sat on her walker and wheeled herself backwards. The SSD tried to talk to the resident. The resident told the SSD she was done. Then, she ignored the SSD. The resident was just different. The SSD indicated she did not really know how to explain what the resident's psychosis symptoms looked like. During an interview, on 1/3/25 at 3:46 p.m., the DON indicated the resident's psychosis was the behaviors she had. When she was experiencing psychosis, they had her at the nurses' station to keep her occupied. She did not respond to redirection at all. The resident was not herself. She did not believe the resident was self-aware of any of the behaviors she demonstrated. The Risperdal (risperidone) manufacturer's label, accessed 1/3/25 at 2:25 p.m. at the accessdata.fda,gov website, had a black box warning which indicated "WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS ...Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Risperdal is not approved for use in patients with dementia-related psychosis." Risperdal's indications for use included only the treatment of schizophrenia, for short-term treatment of acute manic or mixed episodes			

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	155692	A. BUILDING 00 B. WING	01/03/2025

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	associated with Bipolar I disorder, and the treatment of irritability associated with autistic disorders. A current facility policy, revised 11/2016, titled "PSYCHOTROPIC MEDICATIONS," provided by the DON on 1/3/25 at 4:32 p.m., indicated " ...Psychotropic medications shall only be used when there is adequate indication for their use. The facility will not allow psychotropic medications of any type for the purpose of resident discipline of staff convenience ...." 3.1-48(a)(4)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to dispose of unlabeled and unused medications for 2 of 3 medication carts reviewed for medication storage and labeling. (Medication Cart B and Medication Cart C) Findings include: During a medication storage observation of Medication Cart B, accompanied by RN 8 on 1/2/25 at 9:45 a.m., a pill in an unlabeled medication cup was in the second drawer, towards the back of the cart. RN 8 indicated the medication had been pulled from the drawer prior to checking a resident's blood pressure. Since the blood pressure was not within range, the medication was not administered. Two additional pills were found loose on the bottom of the drawer. RN 8 indicated the pills should be disposed of. During an interview with the ADON, on 1/2/25 at 9:48 a.m., she indicated the loose medications	F 0761	No residents were identified as being affected by the deficient practice. All residents do have the potential to be affected by licensed nursing staff not disposing of unlabeled and unused medications in a medication cart. All licensed nurses and QMA's will be in-serviced regarding the facility policy on Medication Storage and the policy on Destruction of Medications with an emphasis placed on not storing loose unlabeled medication in medication carts and that any medication found in this manner should be disposed of immediately per facility policy. The DON or designee will complete weekly audits of two different medication carts to	01/31/2025

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	should be disposed of immediately. During a medication storage observation of Medication Cart C, accompanied by QMA 16 and the ADON on 1/2/25 at 10:03 a.m., a pill in an unlabeled medication cup was in the top drawer. QMA 16 indicated the medication had been there "for a long time." An additional pill was loose at the bottom of the drawer. The ADON indicated the pills should be disposed of. During an interview with the Administrator, on 1/2/25 at 11:22 a.m., she indicated the medication carts had just been gone through a week prior. During an interview with RN 8 on 1/3/25 at 9:51 a.m., she indicated loose pills should be placed in the drug buster solution for disposal. A current, undated facility policy, titled "Destruction of Medications," provided by the Administrator on 1/3/25 at 3:52 p.m., indicated the following: "...All unused, contaminated, or expired prescription drugs shall be disposed of in accordance with state laws and regulations...1) Drugs will be destroyed in a manner that renders the drugs unfit for human consumption and disposed of in compliance with all current and applicable state and federal requirements. 2) Unused, unwanted and non-returnable medications should be removed from their storage area and secured until destroyed...." 3.1-25(j)		ensure medications are stored properly and the carts are free from unlabeled and unused medications. The audit will be completed at a minimum of 4 consecutive weeks or until 100% compliance has been achieved for 4 consecutive weeks. The audits will be reviewed weekly by the DON and facility administrator. When the weekly audits have achieved 100% compliance for 4 consecutive weeks, the audits will be moved to a monthly audit for two months. The monthly audit will be reviewed at the end of each month by the DON and facility administrator. If the two consecutive months of audits have 100% compliance each month, a summary of the audits will be presented to the Quality Assurance Committee each month. At the end of 3 months of monitoring, the summary of audits will be presented to the Quality Assurance Committee for consideration in ending the audits. If the committee concludes that 100% compliance has been achieved for 3 consecutive months, the monitoring will end.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure	F 0880	The licensed nursing staff members who failed to place	01/31/2025

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	transmission-based precautions were implemented to prevent the spread of infectious gastroenteritis for 1 of 9 residents with gastroenteritis (Resident 15). This deficient practice resulted in the development of gastroenteritis for 8 of the remaining 16 residents who resided on the secured unit (Resident 20, 41, 61, 25, 50, 32, 52, and 38). Findings include: During an interview, on 12/27/24 at 9:02 a.m., the Administrator indicated the secured unit had experienced an outbreak. Five residents began experiencing nausea, vomiting, and diarrhea through the night. The residents had been tested for COVID-19, respiratory syncytial virus (RSV), and influenza. The facility was awaiting the results to determine what type of infection the residents had contracted. 1. During an observation, on 12/26/24 at 12:11 p.m., Resident 15 sat in the dining room, eating lunch. Resident 15's clinical record was reviewed on 12/30/24 at 4:09 p.m. Diagnoses included Alzheimer's disease with late onset. Physicians' orders included loperamide (antidiarrheal) 4 milligrams (mg) one time for loose stools (12/25/24), loperamide 2 mg as needed every 24 hours for loose stools for 10 days (12/25/24), ondansetron (for nausea and vomiting) 4 mg every 6 hours as needed for nausea and vomiting for 10 days. A Nurses' Note, dated 12/25/24 at 1:15 p.m., indicated the resident had vomited five to six times and had diarrhea during the shift.		resident #15 in transmission-based precautions after noting the resident had symptoms of nausea and vomiting have been counseled on the fact the resident #15 should have been placed in transmission-based precautions as well as notification made to nursing management staff of the resident's symptoms. All residents do have the potential to be affected if a resident is not placed in transmission-based precautions when experiencing symptoms of nausea and vomiting. All licensed nursing staff will be in-serviced on the facility's policy for Contact Precautions/Nausea & Vomiting. The Director of Nursing or designee will complete a daily review, Monday – Friday, of all resident progress notes to ensure residents having any type of symptom that could be infectious or contagious were placed in appropriate precautions when symptoms started. Progress notes from Saturday and Sunday will be reviewed on Monday. Education will be provided 1:1 with any nurse failing to act appropriately. This review will be completed for a minimum of 12 weeks or until 100% compliance is achieved for 4 consecutive weeks. Each week, the results of the weekly audit will be reviewed by the DON and facility	

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	A Nurses' Note, dated 12/25/24 at 1:32 p.m., indicated the Nurse Practitioner (NP) was notified. New orders were received for loperamide and ondansetron. A Nurses' Note dated 12/25/24 at 2:49 p.m., indicated the resident's representative was notified of the resident's new orders related to the "intestinal flu." The resident's clinical record lacked testing and indication the resident was placed in transmission-based precautions for her symptoms of vomiting and diarrhea. During an interview, on 12/30/24 at 10:02 a.m., the Infection Preventionist (IP) indicated the residents who experienced nausea, vomiting, and/or diarrhea on 12/27/24 had tested negative for COVID-19. The droplet/contact precautions were changed to contact isolation to continue until 48 hours after the resolution of symptoms. She was uncertain who had the first case of gastroenteritis with this outbreak. She had indicated review of the dietary staffing and other staffing had shown no staff had been ill with similar symptoms. She had not worked the week prior to 12/26/24. The DON monitored the infections when she (the IP) had time off. During an interview, on 12/31/24 at 9:08 a.m., RN 5 indicated when a resident experienced vomiting or diarrhea, she would check to see if the symptoms were normal for the resident, then call the physician, check for COVID-19, and put the resident in transmission-based precautions for COVID-19. If the results were negative for COVID-19, then the isolation would be changed from the isolation for COVID-19 to contact		administrator. A summary of the audit records will be presented for review to the Quality Assurance Committee on a monthly basis. The Quality Assurance Committee will discuss the audits and if 100% compliance is achieved on a consistent basis, will discuss ending the audits after 3 months. The committee will discuss whether they feel that all nurses working in the facility have a good understanding of infections and the appropriate precautions for each infection. If the Committee concludes that the nursing department has a clear understanding of infectious diseases and precautions and that there have been 4 consecutive weeks of 100% compliance, the monitoring will conclude. If the committee determines that there are still failures in compliance and understanding after the 12-week period, the monitoring will continue and presented to the Quality Assurance Committee on a monthly basis. When the committee determines that nurses have a good understanding of the infection control process evident by consistent 100% compliance, the monitoring will end.	

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	isolation for the nausea, vomiting, and diarrhea. During an interview, on 12/31/24 at 11:33 a.m., RN 6 indicated if a resident experienced nausea, vomiting, and/or diarrhea, a rapid COVID-19 test would be performed. If the test was negative, then another COVID-19 test would be taken and sent to the hospital. The resident would be placed in transmission-based precautions for COVID-19. If the COVID-19 test sent to the hospital was negative, the precautions would be changed to contact isolation until 48 hours after the resolution of the symptoms. During an interview, on 12/31/24 at 1:33 p.m., the DON indicated when a resident experienced nausea, vomiting, and/or diarrhea, a COVID test was performed and sent to the hospital if the rapid COVID-19 test was negative. The resident was placed in precautions for COVID-19. If the COVID-19 test sent to the hospital was negative, then the resident's precautions were changed to contact isolation for gastroenteritis. An infection screener was to be filled out whenever an infection was suspected. She was unaware Resident 15 had experienced multiple episodes of vomiting prior to the outbreak of eight other residents with gastroenteritis. She was uncertain if Resident 15 had been tested for COVID-19 or had been put in transmission-based precautions. During an interview, on 1/3/25 at 3:45 p.m., the DON indicated Resident 15 had not been tested for COVID-19 or been put on transmission-based precautions as she would have expected to be done. 2. During an observation, on 12/26/24 at 12:10 p.m., Resident 41 sat in a chair in the dining room, eating lunch.			

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Resident 41's record was reviewed on 12/31/24 at 10:01 a.m. She shared a room with Resident 15. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.

A Nurses' Note, dated 12/27/24 at 10:49 a.m., indicated the resident had vomiting and diarrhea.

An Infection Report, dated 12/27/24 at 11:28 a.m., indicated McGeer's criteria (used to define infections for long-term care) was met for gastroenteritis (inflammation of the stomach and intestines).

3. During an observation, on 12/26/24 at 12:18 p.m., Resident 20 sat in her wheelchair in the dining room.

During an observation, on 12/27/24 at 9:07 a.m., Resident 20's door had an isolation sign on it and was closed.

Resident 20's clinical record was reviewed on 12/30/24 at 11:11 a.m. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.

A Nurses' Note, dated 12/27/24 at 5:41 a.m., indicated the resident vomited. The rapid COVID-19 test was negative.

An Infection Report, dated 12/27/24 at 11:31 a.m., indicated McGeer's criteria was met for gastroenteritis.

4. During an observation on 12/26/24 at 12:09 p.m.,

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	Resident 61 sat in a chair in the dining room eating her lunch with the assistance of her resident representative. During an observation on 12/27/24 at 9:07 a.m., Resident 61's door was closed with an isolation sign on it. Resident 61's clinical record was reviewed on 12/30/24 at 3:03 p.m. Diagnoses included Alzheimer's disease with early onset. A Nurses' Note, dated 12/27/24 at 3:00 a.m., indicated the resident wandered into the hallway holding feces in her hand. She was assisted back into her room and began vomiting into her bathroom sink. She continued to vomit. An Infection Report, dated 12/27/24 at 11:21 a.m., indicated McGeer's criteria was met for gastroenteritis. 5. During an observation, on 12/26/24 at 12:12 p.m., Resident 25 sat at a table in the dining area, eating lunch. Resident 25's clinical record was reviewed on 12/31/24 at 10:04 a.m. Diagnoses included unspecified dementia, unspecified severity, with anxiety. A Nurses' Note, dated 12/27/24 at 11:08 a.m., indicated the resident vomited and had diarrhea. An Infection Report, dated 12/27/24 at 11:27 a.m., indicated McGeer's criteria was met for gastroenteritis. 6. During an observation, on 12/26/24 at 12:19 p.m., Resident 50 sat at a table in the dining room			

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	and fed herself lunch. During an observation, dated 12/27/24 at 9:07 a.m., Resident 50's door was closed with an isolation sign on it. Resident 50's clinical record was reviewed on 12/31/24 at 10:05 a.m. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A Nurses' Note dated, 12/27/24 at 11:21 a.m., indicated the resident experienced nausea, vomiting, and diarrhea. An Infection Report, dated 12/27/24 at 11:30 a.m., indicated McGeer's criteria was met for gastroenteritis. 7. During an observation, on 12/26/24 at 12:18 p.m., Resident 32 sat in the dining room, eating lunch. During an observation, on 12/27/24 at 9:09 a.m., Resident 32's door was closed with an isolation sign on it. Resident 32's clinical record was reviewed on 12/31/24 at 12:25 p.m. Diagnoses included unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A Nurses' Note, dated 12/27/24 at 2:27 a.m., indicated the resident had vomited all over himself, his bed, and his floor. He was also covered in feces. A Nurses' Note, dated 12/27/24 at 2:59 a.m.,			

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	155692	A. BUILDING 00 B. WING	01/03/2025

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	indicated the resident vomited again and had more diarrhea. An Infection Report, dated 12/27/24 at 11:32 a.m., indicated McGeer's criteria was met for gastroenteritis. 8. During an observation, on 12/26/24 at 12:18 p.m., Resident 52 sat in a wheelchair at a table in the dining room. Resident 52's clinical record was reviewed on 12/31/24 at 10:06 a.m. Diagnoses included Alzheimer's disease, unspecified. A Nurses' Note, dated 12/28/24 at 8:05 a.m., indicated Resident 52 was covered in emesis and diarrhea. She was placed in COVID-19 transmission-based precautions. A Nurses' Note, dated 12/29/24 at 6:46 a.m., indicated the resident's COVID-19 results were negative, and the resident was put on contact isolation. 9. Resident 38's clinical record was reviewed on 12/30/24 at 4:07 p.m. Diagnoses included Alzheimer's disease with late onset. A Nurses' Note, dated 12/27/24 at 11:24 p.m., indicated the resident experienced nausea, vomiting, and diarrhea. A Nurses' Note, dated 12/27/24 at 3:52 p.m., indicated the resident was given an ondansetron pill for nausea and vomiting. An Infection Report, dated 12/27/24 at 11:29 p.m., indicated McGeer's criteria was met for gastroenteritis.			

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	"Norovirus Facts and Stats," (May 2024) was retrieved on 1/3/25 from the Centers for Disease Control and Prevention (CDC) website. The guidance included the following: " ...Norovirus is the leading cause of vomiting and diarrhea from acute gastroenteritis among all people of all ages in the United States ...." "Norovirus infection," (March 2022) was retrieved on 1/3/25 from the Mayo Clinic website. The guidance included the following: " ...Norovirus infection can cause severe vomiting and diarrhea that starts suddenly. Noroviruses are highly contagious ...Diarrhea, stomach pain, and vomiting typically begin 12 to 48 hours after exposure. Norovirus infection symptoms usually last 1 to 3 days ...Norovirus infection occurs most frequently in closed and crowded environments. Examples include hospitals, nursing homes ...." A current, undated facility policy, titled "Contact Precautions/Nausea & Vomiting," provided by the Administrator on 1/2/25 at 9:05 a.m., indicated the following: " ...Contact precautions are used for patients who are known or suspected to be infected with microorganisms that can be transmitted by [1] Direct contact with the patient [2] Indirect contact with environmental surfaces or patient care items [3] Secretions or drainage that cannot be contained ...Contact precautions for residents can be removed when resident has been free from nausea & vomiting and are showing no other signs of infection for 48 hours ...." 3.1-18(b)(2)			
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	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: December 26, 27, 30, 31, 2024 and January 2 and 3, 2025. Facility number: 002910 Residential Census: 50 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 14, 2025.	R 0000		
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance Based on record review and interview, the facility failed to complete tuberculin tests according to state and federal guidelines for 7 of 10 residents reviewed for infection control. (Residents 8, 9, 14, 16, 19, 22, and 24) Findings include: 1. A review of Resident 8's clinical record, on 1/3/24 at 9:35 a.m., indicated the resident had diagnoses which included, but were not limited to, hypertension, gastro-esophageal reflux disease without esophagitis, and mixed hyperlipemia. A step 1 tuberculin skin test was administered on 4/25/24 at 1:00 p.m. Results were recorded as negative, but did not include a date or time when the test was read. A step 2 tuberculin skin test was administered on 5/11/24 at 9:10 a.m. Results were recorded as negative, but did not include a date or time when the test was read.	R 0410	In efforts to prevent unnecessary concern or stress for the residents determined to be out of compliance, a chart review will be completed to determine if a chest x-ray stating the resident was free from active disease was completed no more than 6 months of admission to the facility. If there is a chest x-ray on file within the stated timeframe, an updated Tuberculosis Risk Assessment will be completed for the resident. If no chest x-ray is on file, a two-step tuberculin skin test will be initiated. An audit will be completed to determine if any other residents residing in the assisted living facility are not compliant in meeting the requirements for	01/31/2025

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	2. A review of Resident 9's clinical record, on 1/3/24 at 9:46 a.m., indicated the resident had diagnoses which included, but were not limited to, hypertension, hyperparathyroidism, hypercholesterolemia, and generalized anxiety disorder. A step 1 tuberculin skin test was administered on 4/25/24 at 2:00 p.m. Results were recorded as negative, but did not include a date or time when the test was read. A step 2 tuberculin skin test was administered on 5/11/24 at 9:12 a.m. Results were recorded as negative, but did not include a date or time when the test was read. 3. A review of Resident 14's clinical record, on 1/3/24 at 9:54 a.m., indicated the resident had diagnoses which included, but were not limited to, hypertension, anxiety disorder, panic disorder, and mild cognitive impairment. A step 1 tuberculin skin test was administered on 6/18/24 at 1:38 p.m. Results were recorded as negative, but did not include a date or time when the test was read. A step 2 tuberculin skin test was administered on 7/2/24 at 1:15 p.m. Results were recorded as negative, but did not include a date or time when the test was read. 4. A review of Resident 16's clinical record, on 1/3/24 at 10:02 a.m., indicated the resident had diagnoses which included, but were not limited to, hypertension, mixed hyperlipidemia, chronic kidney disease (stage 3), and chronic obstructive pulmonary disease. A step 1 tuberculin skin test was administered on 11/18/2024 at 12:36 p.m. Results were recorded as negative, but did not include a date or time when		baseline tuberculin testing. In efforts to prevent unnecessary concern or stress for the residents, a chart review will be completed on those that failed to have appropriately documented baseline tuberculin testing to determine if a chest x-ray stating the resident was free from active disease was completed no more than 6 months of admission to the facility. If there is a chest x-ray on file within the stated timeframe, an updated Tuberculosis Risk Assessment will be completed for the resident. If no chest x-ray is on file nor appropriately documented tuberculin testing, a two-step tuberculin skin test will be initiated for the resident. All licensed nursing staff will be in-serviced on the facility policy for Tuberculosis Assessment and Testing of Long-Term Care Residents with an emphasis on how the results of the testing should be documented to include the date and time the tuberculin test was read. Following the audit of residents currently residing in the assisted living facility, the DON or designee will audit all newly admitted residents to the assisted living facility for compliant documentation of baseline tuberculin testing. The DON will complete the audit for three months or until 100% compliance has been achieved with tuberculin	

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	155692	A. BUILDING 00 B. WING	01/03/2025

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	the test was read. A step 2 tuberculin skin test was administered on 12/02/2024 at 12:55 p.m. Results were recorded as negative, but did not include a date or time when the test was read. 5. A review of Resident 19's clinical record, on 1/3/24 at 10:17 a.m., indicated the resident had diagnoses which included, but were not limited to, atrial fibrillation, hypertension, benign hypertrophic hyperplasia, and heart failure. A step 1 tuberculin skin test was administered on 1/20/2024 at 11:45 a.m. Results were recorded as negative, but did not include a date or time when the test was read. A step 2 tuberculin skin test was administered on 12/4/24 at 1:15 p.m. A progress note, dated 12/6/24 at 11:01 a.m., indicated the step 2 tuberculin skin test was read approximately 2 hours short of 48 hours. 6. A review of Resident 22's clinical record, on 1/3/24 at 1:06 p.m., indicated the resident had diagnoses which included, but were not limited to, chronic kidney disease (stage 3), hypertension, juvenile arthritis, hyperlipidemia, and polymyalgia rheumatica. A step 1 tuberculin skin test was administered on 7/15/24 at 10:33 a.m. Results were recorded as negative, but did not include a date or time when the test was read. A step 2 tuberculin skin test was administered on 7/31/24, with no time specified. Results were recorded as negative, but did not include a date or time when the test was read. 7. A review of Resident 24's clinical record, on 1/3/24 at 1:44 p.m., indicated the resident had diagnoses which included, but were not limited to, Parkinson's disease with dyskinesia,		testing documentation. Audit records will be reviewed by the Quality Assurance Committee until consistent substantial compliance has been achieved as determined by the committee.	

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	hyperlipidemia, insomnia, and Vitamin B-12 deficiency anemia. A step 1 tuberculin skin test was administered on 9/16/24, with no time specified. Results were recorded as negative, but did not include a date or time when the test was read. A step 2 tuberculin skin test was administered on 9/30/24 at 10:31 a.m. Results were recorded as negative, but did not include a date or time when the test was read. During an interview with the DON, on 1/3/24 at 10:16 a.m., she indicated the electronic medical record program used for documentation did not offer a place to record the time of the test results. Test results were reviewed between 48 to 72 hours after administration. She had not considered the results might not be read timely. A current, undated facility policy titled "Tuberculosis Assessment and Testing of Long-term Care Residents," provided by the Administrator on 1/3/25 at 2:47 p.m., indicated the following: "...The facility screens residents for tuberculosis in accordance with state requirements as part of the facility's overall infection prevention and control program...1) The standard test method for the tuberculin skin test...should be read at 48 to 72 hours...."			