STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155242	A. BUILDING 00 B. WING	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SIGNATURE HEALTHCARE OF MUNCIE	4301 N WALNUT ST MUNCIE, IN 47303

(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 the Investigation of Complaints IN00418061 and IN00417645. Complaint IN00418061 - Federal/State deficiencies related to the allegations are cited at F580. Complaint IN00417645 - Federal/State deficiencies related to the allegations are cited at F600. Unrelated deficiencies are cited. Survey dates: September 26, 27 and 28, 2023. Facility number: 000146 Provider number: 155242 AIM number: 100291200 Census Bed Type: SNF/NF: 118 Total: 118 Census Payor Type: Medicare: 11 Medicaid: 90 Other: 17 Total: 118 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 6, 2023.	F 0000	It is the practice of this provider to ensure that federal participation requirements for nursing homes participating in Medicare &/or Medicaid programs are met in accordance with federal and state law. This provider respectfully requests that this CMS-2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review on, or after 10/18/2023.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric Ahlbrand	CEO-Administrator	10/23/2023

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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	physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as			

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	defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review the facility failed to notify the resident's physician when blood sugars were outside of parameters for 2 of 3 residents reviewed for blood sugars (Resident C and Resident M). Findings include: 1. Resident C's clinical record was reviewed on 9/26/23 at 10:00 a.m. Diagnoses included type 2 diabetes mellitus without complications, cognitive communication deficit, aphasia, dietary counseling and surveillance, type 2 diabetes mellitus with ketoacidosis without coma, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. His medications included take blood sugar at 6:00 a.m. daily, insulin glargine (treat high blood sugar) 22 units daily (7:00 a.m. to 11:00 a.m.), insulin lispro (treat high blood sugar) 5 units before meals (7:00 a.m., 11:15 a.m. and 5:00 p.m.), insulin lispro per sliding scale three time daily (8:00 a.m., 12:00 p.m. and 5:30 p.m.) , if his blood sugar was less than 60, call the physician...if his blood sugar was greater than 500, call the physician, Glucagon (treat low blood sugar) 1 milligram (mg) as needed for blood sugars less than 60, and document side effects of hyperglycemic related to insulin medication use - observe him closely for side effects: confusion, sweating, shortness of breath, fruity breath, weakness, fatigue, increased thirst,	F 0580	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Resident L no longer resides at the facility. Resident M was assessed for any change of condition and MD reviewed the last 30 days of blood sugars. 2) How the facility identified other residents:	10/18/2023

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	increased urination, shakiness, pale skin, and lethargy every shift. He had a current care plan for a diagnosis of diabetes and he was at risk for unstable blood glucose as evidenced by hyperglycemia with signs and symptoms of increased thirst, headaches, blurred vision, increased urination, fatigue, weight loss, blood sugars more than 180 mg/dl (milligram/deciliter) and hypoglycemia with signs and symptoms of shakiness, dizziness, sweating, intense hunger, irritability, anxiety, decreased level of consciousness, headache. He continued to have fluctuating blood sugars, elevated into mid 300's at times. He was a brittle diabetic and even minimal changes in insulin or other diabetic medication could cause significant affects. The staff and physician felt multiple medication changes as result of fluctuating blood sugars was not the best intervention for him. Continue to monitor him for glucose levels per physician order (1/26/23). Interventions included blood glucose monitoring as indicated (1/26/23), notify physician with significant changes in signs and symptoms (1/26/23). Review of the clinical record indicated on 8/8/23 at 6:04 a.m., his blood sugar was 49 mg/dl. His insulin glargine 22 units and his insulin lispro 5 units were not administered. He was given two fig bars. On 8/8/23 at 10:12 a.m., his blood sugar was 109 mg/dl. The clinical record lacked documentation of a physician notification of the low blood sugar. On 8/20/23 at 6:07 a.m. and 6:09 a.m., his blood sugar was 41 mg/dl.		A facility wide review of all residents with a diagnosis of diabetes and with an order for an has been reviewed to ensure they have call parameters. 3) Measures put into place/ System changes: All licensed staff will be educated related to, including but not limited to, Notification of changes (injury/decline/room, etc.). The DON/ADON/UM/SDC or Clinical Consultant will audit the Facility Activity Report for any blood sugar out of range to ensure proper documentation has been completed. This audit will be completed daily (M-F) X 8 weeks. Any identified concerns will be immediately addressed with the responsible individual(s). 4) How the corrective actions will be monitored:	

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	On 8/20/23 at 6:15 a.m., a notation was made in his MAR, his insulin lispro 5 units was not administered due to his blood sugar of 41 mg/dl. On 8/20/23 at 10:56 a.m., his blood sugar was 175 mg/dl. The clinical record lacked documentation of a physician notification or an intervention other than holding the insulin, to treat the low blood sugar. A nurses note, dated 8/27/23 at 12:40 p.m., indicated his blood sugar was 38 mg/dl and PRN (as needed) GlucaGen (treat low blood sugar) was administered per order. The clinical record lacked documentation of a physician notification of the low blood sugar. A nurses note, dated 8/27/23 at 12:55 p.m., indicated glucose was given and his blood sugar was 234 mg/dl. He walked around and ate lunch. He had no signs or symptoms of hypoglycemia. 2. Resident M's clinical record was reviewed on 9/28/23 at 11:02 a.m. Diagnoses included type 2 diabetes mellitus with hyperglycemia, body mass index (BMI) 40 - 44.9, and morbid (severe) obesity due to excess calories. His medications included insulin lispro 10 units three times daily (7:00 a.m., 11:15 a.m. and 5:00 p.m.), insulin glargine 40 units daily (7:15 a.m. to 11:00 a.m.), metformin (treat diabetes) 1,000 mg twice daily, and document side effects of hyperglycemic related to insulin medication use - observe him closely for side effects: confusion, sweating, shortness of breath, fruity breath,		After 8 weeks, to ensure continued compliance, the DON/UM/ADON/SDC or Clinical Consultant will continue to review the Facility Activity Report M-F for any blood sugar out of range and to ensure proper documentation was completed. Any identified concerns will be immediately addressed with the responsible individual(s). The facility, through the QAPI program, will review, update, and make changes, as necessary, to this plan of correction to ensure substantial compliance for no less than 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until the QA Committee determines compliance is achieved or if ongoing monitoring is required. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	weakness, fatigue, increased thirst, increased urination, shakiness, pale skin, and lethargy every shift. He had a current care plan for a diagnosis of diabetes and he was at risk for unstable blood glucose as evidenced by hyperglycemia with signs and symptoms of increased thirst, headaches, blurred vision, increased urination, fatigue, weight loss, blood sugars more than 180 mg/dl and hypoglycemia with signs and symptoms of shakiness, dizziness, sweating, intense hunger, irritability, anxiety, decreased level of consciousness, headache. He had started refusing metformin, the reason was unknown. The physician was made aware of the refusals. A registered dietician referral, continued non compliance with diet restrictions (8/2/23). His interventions included blood glucose monitoring as indicated (8/2/23) and notify physician with significant changes in signs and symptoms (8/2/23). On 8/13/23 at 7:38 a.m., his blood sugar was documented as "high". The clinical record lacked physician notification for the high blood sugar. On 9/19/23 at 6:10 a.m., his blood sugar was documented as "high". The clinical record lacked physician notification for the high blood sugar. During an interview with LPN 7, on 9/27/23 at 3:55 p.m., she indicated she would call the doctor if a residents blood sugar was out of parameters, she would put a nurses note in and recheck the resident's blood sugar.			

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	During an interview with the LPN/Unit Manager, with the Social Service Director present, on 9/28/23 at 1:49 p.m., she indicated if a resident's blood sugars were below or above parameters she would call the physician for any new orders. The staff should put a nurses note in and recheck the blood sugar. If the blood sugar was below parameters they were allowed to give orange juice and a snack. During an interview with RN 29, on 9/28/23 at 2:44 p.m., she indicated if the blood sugars were out of parameters she would call the physician for recommendations, put in a nurses note and recheck the blood sugar. A 9/15/23 revised facility policy, titled "Notification of Change of Condition," provided by the Administrator, on 9/27/23 at 3:02 p.m., indicated the following: "...Guidelines: 1. The facility must...consult with the residents' physician...when there is...c. A need to alter treatment significantly...2. Documentation of notification or notification attempts should be recorded in the residents electronic medical record...." This Federal tag relates to complaint IN00418061. 3.1-5(a)(3)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to			

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	freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observations, interviews, and record review, the facility failed to protect the resident's right to be free from verbal abuse by CNA 4 for 1 of 7 residents reviewed for abuse (Resident B and CNA 4). Findings include: On 9/26/23 at 3:09 p.m., Resident B was observed ambulating with her walker in the hallway. She indicated staff was nice to her and they better be. No one had ever been mean to her and she wouldn't put up with it, she paid the bill at the facility. On 9/28/23 at 4:02 p.m., Resident B was observed ambulating with her walker in the hallway. Resident B's clinical record was reviewed on 9/26/23 at 11:45 a.m. Diagnoses included major depressive disorder, recurrent, Alzheimer's disease. unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A quarterly Minimum Data Set (MDS) assessment, dated 7/5/23, indicated she was unable to complete the Brief Interview for Mental Status (BIMS).	F 0600	ol class="NumberListStyle1 SCXW251428091 BCX0" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" 1) Resident B has been assessed for any changes with mental status, anguish, or distress. The allegation Resident B discussed with the surveyor had already been reported to IDOH with the investigation completed. The care plan has been updated to reflect the of the . An investigation was completed on CNA 4. CNA 4 was re-educated on abuse and customer service. RN 25 was re-educated on who to report any type of abuse to. 2) A one-time resident interview process has been completed for the current population, completed on 9/26/23, with no other issues identified during the	10/18/2023

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	She had a current care plan for being at risk for change in mood state, she report a stakeholder hit and grabbed her on her arm while conversing with her in the hallway. Upon investigation, she complained of pain in her right wrist and arm on 8/18/23, relating pain to blood draw on 8/4/23. In addition, she was noted to be instructing another resident on her hallway the other resident didn't belong on her hall. Aide was in hallway, and did interject and offer the other resident does live on same hall, resident then made negative comment "You hit me". Witness statements do not support resident getting hit. Resident had potential verbal encounter with staff member. Resident does not express any negative statements regarding aide, and appears resident did not hear negative comment voiced out loud. Resident has not expressed any conversation related to possible negative comment by aide. No change in mental status or demeanor at present (8/19/23). Her interventions included encourage and allow open expressions of feeling(8/19/23), observe effectiveness/side effects of medications as ordered (8/19/23), provide regular opportunities for: physical activity, daily decision making, stimulation, socialization, leisure activities consistent with interests (8/19/23), report to physician changes in mood status (8/19/23) and support resident's strengths and coping skills (8/19/23). A nurses note, dated 9/16/23 at 2:25 p.m., indicated during breakfast tray pass, Resident B saw the cart in the hallway and began to worry about her breakfast getting cold. She walked back and forth in the hallway until she found CNA 4, who was working that hall. She began following CNA 4 and talking about the fact she wanted her breakfast now while it was hot. CNA 4 continued		interview/resident assessment process. An Ad Hoc QAPI meeting was held on 9/27/23 with the Medical Director and QAPI Team. The facility staff have been re-educated on abuse prohibition, to include verbal abuse. ol class="NumberListStyle1 SCXW251428091 BCX0" role="list" start="3" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" 3) It is the responsibility of the facility staff to uphold the abuse prohibition policy and procedure and to refrain from swearing and yelling while working in the facility. The Director of Nursing, Assistant Director of Nursing, Unit Manager, Shift Supervisor, Clinical Consultant, and/or the Administrator will be responsible to interview staff on abuse prohibition, including if there had been any situation not reported immediately to the Abuse Coordinator 3 times a week for (4) four weeks, two times weekly for (4) four weeks; weekly for (4) four weeks; then monthly for three months. Any issues identified will be immediately corrected, 1:1	

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	with her passing order. Resident B became aggressive with her tone and continued to follow her room to room. CNA 4 said out loud "Ok, I will make sure you get your tray last you mean old woman." There was no response or reaction from Resident B. The shift supervisor, DON, family and physician were informed. The facility investigation was reviewed on 9/26/23 at 10:55 a.m. and indicated the following: A hand written statement by CNA 4, dated 9/16/23, indicated Resident B chased down the hall demanding he tray first. Resident B was in her face yelling at her. As Resident B walked away CNA 4 said under her breath, she could just make sure she got her tray last. As soon as she said it, she regretted it and got Resident B's tray first and took it straight into her room. A handwritten statement by RN 25, dated 9/16/23, indicated CNA 4 was passing trays on the 300 hall. Resident B was upset about cold food and she wanted her tray. She was aggressive in her speech and continue to follow CNA 4 as she passed trays. CNA 4 said out loud "Ok, I will make sure you are last one to get your tray, you mean old woman." Resident B had no reaction. During an interview with CNA 4, on 9/26/23 at 11:36 a.m., she indicated lunch trays were being served. Resident B was chasing her down the hall, yelling and spitting on her. They were running behind and her tray was the last on one on the cart. She wanted her tray. It was her first time working on that hall. She did not call her a mean old woman. She was provided with education on verbal abuse, all the types of abuses and suspended for three days.		re-education completed for stakeholder as identified, up to and including disciplinary action as determined necessary by the Administrator and Director of Nursing. 4) The Administrator will review the audits completed on a weekly basis. Results of the reviews will be forwarded to the Quality Assurance Performance Improvement Committee monthly for 3 months, and then quarterly for 3 quarters. Based on evaluation of audits and observations, the QAPI Committee determined the facility is in substantial compliance on 10/10/23. Audit documentation will continue to be submitted to the QAPI committee for review and to ensure compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance.	

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	During an interview with RN 25, on 9/26/23 at 3:49 p.m., she indicated Resident B was following CNA 4 around wanting her tray. CNA 4 had her back to Resident B. RN 25 was at her medication cart and CNA 4 was coming down the hall, Resident B was right behind her. CNA 4 said "Oh, ok, I will make sure you get served last you mean old woman." CNA 4 could had avoided the whole situation and things being said if she would just had given her the tray. She reported it to the weekend supervisor. A 9/15/23 revised facility policy, titled "Abuse, Neglect and Misappropriation of Property," provided by the Administrator on 9/27/23 at 3:02 p.m., indicated the following: "...It is the organization's intention to prevent the occurrence of abuse...Verbal Abuse is the use of any oral, written or gestured language that includes any threat, or any frightening, disparaging or derogatory language, to residents or their families, or within their hearing distance, regardless of age, ability to comprehend, or disability...." This Federal tag relates to complaint IN00417645. 3.1-27(b)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are			

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	reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to ensure allegations of abuse were reported to the State Agency timely for 3 of 7 residents reviewed for abuse allegations (Resident L and CNA 6, Resident K and CNA 6 and Resident F and CNA 13.) Findings include: Confidential interviews were conducted during the course of the survey. During a confidential interview, it was indicated Resident L yelled at CNA 6 to get out of her face because she didn't want her hair brushed. CNA 6 told Resident L when someone told her to get out of her face, she won't, because no one would talk to her like that. That same day, Resident K said	F 0609	ol class="NumberListStyle1 SCXW22017365 BCX0" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" 1) Resident L was assessed by the Social Services Director and Director of Nursing upon report of the negative statements. There were no signs of a change in mental status, free of signs or symptoms of mental anguish or distress. There were no visible changes to resident appearance or skin. The care plan has been	10/18/2023

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	something about CNA 6's mom. CNA 6 told Resident K that no one talked about her mom and if she did she was going to go to jail. Resident K had anxiety and with CNA 6 telling her she was going to go to jail caused her more anxiety and she began to cry and got worked up. They were taught about the signs of abuse through education and to report. The incidents were immediately reported to the DON and she had the staff make out statements. During a confidential interview, it was indicated CNA 6 wanted to comb Resident L's hair. Resident L had a knot in her hair that needed worked on. Resident L was upset and didn't want her hair combed. She kept telling CNA 6 to get out of her face and get away from her. CNA 6 was not reading Resident L's body language and that she was upset. CNA 6 needed to reapproach Resident L at a later time, it was reported to the DON and she had the staff make out statements. During an interview with the DON, on 9/27/23 at 10:21 a.m., she indicated when she asked the nurse about the incidents with CNA 6, she indicated to her she didn't feel like it was abuse. She wasn't sure if statements were made out, but she would look. During an interview with Resident F, on 9/26/23 at 11:52 a.m., she indicated she sat near a resident in the dining who was a fall risk. She watched the resident for the staff because she liked to get up and she was a fall risk. She had told an unidentified CNA, the resident was getting up and the CNA told her to "shut up". This happened about a month ago, she did not report it right away, but reported it to the DON about three weeks ago. She was offended by her telling her to shut up, that was not how people were supposed		updated to reflect the of the . This incident was reported to ISDH. 2) Resident K was assessed with no negative findings. When interviewed, Resident K had no recollection of the incident and denied having any concerns with any staff members. Resident F was assessed by the Social Services Director with no negative findings. There were no visible changes to resident appearance or skin. The care plan has been updated to reflect the of the . This incident was reported to ISDH. CNA 6 is no longer employed by Signature Healthcare. ol class="NumberListStyle1 SCXW22017365 BCX0" role="list" start="2" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" 3) A one-time resident interview process has been completed for the current population, completed on 9/26/23, with no other issues identified during the interview/resident assessment process. An Ad Hoc QAPI meeting was held on 9/27/23 with the Medical Director and QAPI Team. The facility staff have been	

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	to be treated, but nothing was done about it and the CNA still worked at the facility. She didn't know the CNA's name, but she could recognize her. During an interview with the DON, on 9/26/23 at 12:00 p.m., she indicated she was not aware of the incident with Resident F. The DON approached Resident F, and Resident F explained the incident to her. The DON indicated she honestly did not remember her reporting the incident to her and she would take care of it. Resident F's clinical record was reviewed on 9/26/23 at 3:14 p.m. Diagnoses included other specified depressive, episodes, generalized anxiety disorder and cognitive communication deficit. Her medications included buspirone (treat anxiety) 10 mg three times daily, and desvenlafaxine succinate (treat depression) 100 mg daily. A quarterly MDS, dated 8/11/23, indicated she was cognitively intact. On 9/27/23 at 9:49 a.m., Resident L was observed in bed. She indicated everyone was nice to her. Resident L's clinical record was reviewed on 9/27/23 at 4:15 p.m. Diagnoses cognitive communication deficit, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Her medications included escitalopram oxalate (treat anxiety) 10 mg (mg) daily. A 6/3/23 quarterly MDS indicated she was cognitively intact. No behaviors were exhibited.		re-educated on abuse prohibition, to include verbal abuse. 4) It is the responsibility of the facility staff to uphold the abuse prohibition policy and procedure and to refrain from swearing and yelling while working in the facility. The Director of Nursing, Assistant Director of Nursing, Unit Manager, Shift Supervisor, Clinical Consultant, and/or the Administrator will be responsible to interview staff on abuse prohibition, including if there had been any situation not reported immediately to the Abuse Coordinator 3 times a week for (4) four weeks, two times weekly for (4) four weeks; weekly for (4) four weeks; then monthly for three months. Any issues identified will be immediately corrected, 1:1 re-education completed for stakeholder as identified, up to and including disciplinary action as determined necessary by the Administrator and Director of Nursing. p paraid="663717715" paraeid="{f396b5d4-b6be-4116-913e-74c1013a0700}{158}" >	

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	She had a current behavioral care plan for refusal of treatment or care. As example by, refusal of care, medications, getting out bed, showers and brushing hair (revised on 9/18/23). Her interventions included converse with her to determine why she refused (3/6/23), converse with her during care to explain procedure (7/5/22), educate her regarding the importance of care and treatment to her health (7/5/22), have another staff member address her (7/5/22), offer another time for care (7/5/22) and provide positive reinforcement (7/5/22). Her clinical record lacked documentation of the incident with CNA 6. On 9/27/23 at 9:49 a.m., Resident K was observed sitting on the side of her bed. She indicated everyone was nice to her. Resident K's clinical record was reviewed on 9/27/23 at 3:56 p.m. Diagnoses included cognitive communication deficit, generalized anxiety disorder, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Her medications included escitalopram oxalate 20 milligram daily and trazodone (treat depression) 50 mg daily. A 8/15/23 quarterly Minimum Data Set (MDS), indicated she was severely cognitively impaired. No behaviors were exhibited. Her clinical record lacked documentation of the incident with CNA 6.		The Administrator will review the audits completed on a weekly basis. Results of the reviews will be forwarded to the Quality Assurance Performance Improvement Committee monthly for 3 months, and then quarterly for 3 quarters. Based on evaluation of audits and observations, the QAPI Committee determined the facility is in substantial compliance on 10/18/23. Audit documentation will continue to be submitted to the QAPI committee for review and to ensure compliance goals. QAPI committee reserves the right to modify or extend monitoring times according to outcomes. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance.	

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	A 9/15/23 revised facility policy, titled "Abuse, Neglect and Misappropriation of Property," provided by the Administrator on 9/27/23 at 3:02 p.m., indicated the following: "...Verbal Abuse is the use of any oral, written or gestured language that includes any threat, or any frightening, disparaging or derogatory language, to residents or their families, or within their hearing distance, regardless of age, ability to comprehend, or disability...Allegation of Abuse: This means a report, complaint, grievance, statement, incident or other facts that a reasonable person would understand to mean that abuse, as defined in this policy, is occurring, has occurred, or plausibly might have occurred...Any abuse allegation must be reported to the State within 2 hours from the time the allegation was received...." 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate			

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	corrective action must be taken. Based on observation, interview, and record review, the facility failed to ensure allegations of abuse were investigated for 3 of 7 residents reviewed for abuse allegations (Resident L and CNA 6, Resident K and CNA 6 and Resident F and CNA 13). Findings include: Confidential interviews were conducted during the course of the survey. During a confidential interview, it was indicated Resident L yelled at CNA 6 to get out of her face because she didn't want her hair brushed. CNA 6 told Resident L when someone told her to get out of her face, she won't, because no one would talk to her like that. That same day, Resident K said something about CNA 6's mom. CNA 6 told Resident K that no one talked about her mom and if she did she was going to go to jail. Resident K had anxiety and with CNA 6 telling her she was going to go to jail caused her more anxiety and she began to cry and got worked up. They were taught about the signs of abuse through education and to report. The incidents were immediately reported to the DON and she had the staff make out statements. During a confidential interview, it was indicated CNA 6 wanted to comb Resident L's hair. Resident L had a knot in her hair that needed worked on. Resident L was upset and didn't want her hair combed. She kept telling CNA 6 to get out of her face and get away from her. CNA 6 was not reading Resident L's body language and that she was upset. CNA 6 needed to reapproach Resident L at a later time, it was reported to the DON and she had the staff make out statements.	F 0610	ol class="NumberListStyle1 SCXW250548321 BCX0" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident L was assessed physically and for psychosocial. The MD was updated, and the incident was reported to ISDH. Resident K was interviewed with no recollection of the incident. Resident K was asked if she had any concerns with any staff members which she no. Resident F was assessed physically and for psychosocial. The MD was updated, and the incident was reported to ISDH. p paraid="905030467" paraeid="{f8c357f3-429c-4d72-b3ce-40f64d3e7d38}{68}" >CNA 6 no longer is employed with Signature Healthcare. How be identified and what corrective action will be taken?	10/18/2023

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	During an interview with the DON, on 9/27/23 at 10:21 a.m., she indicated when she asked the nurse about the incidents with CNA 6, she indicated to her she didn't feel like it was abuse. She wasn't sure if statements were made out, but she would look. During an interview with Resident F, on 9/26/23 at 11:52 a.m., she indicated she sat near a resident in the dining who was a fall risk. She watched the resident for the staff because she liked to get up and she was a fall risk. She had told an unidentified CNA, the resident was getting up and the CNA told her to "shut up". This happened about a month ago, she did not report it right away, but reported it to the DON about three weeks ago. She was offended by her telling her to shut up, that was not how people were supposed to be treated, but nothing was done about it and the CNA still worked at the facility. She didn't know the CNA's name, but she could recognize her. During an interview with the DON, on 9/26/23 at 12:00 p.m., she indicated she was not aware of the incident with Resident F. The DON approached Resident F, and Resident F explained the incident to her. The DON indicated she honestly did not remember her reporting the incident to her and she would take care of it. Resident F's clinical record was reviewed on 9/26/23 at 3:14 p.m. Diagnoses included other specified depressive, episodes, generalized anxiety disorder and cognitive communication deficit. Her medications included buspirone (treat anxiety) 10 mg three times daily, and desvenlafaxine succinate (treat depression) 100 mg daily.		·All residents have the potential to be affected; therefore, a facility wide questionnaire regarding abuse was completed on 9/27/2023 with all residents with a BIMS of 8 or greater to ensure proper documentation was completed and if an investigation was warranted. The nurse's notes were reviewed from 9/1/2023 – 9/30/2023 to review for any documentation that may warrant an investigation. The IDT team has been re-educated on what to report to ISDH and the timeframe for reporting. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Beginning 10/13/2023, the DON/ADON/Unit Managers/SDC/TCN or Clinical Consultant will review the Facility Activity Report for documented notes that may warrant an investigation. The DON or Clinical Consultant will review all incidents to ensure corrective actions were completed and reported to ISDH. This audit will be reviewed M-F weeks. p paraid="755340880"	

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	A quarterly MDS, dated 8/11/23, indicated she was cognitively intact. On 9/27/23 at 9:49 a.m., Resident L was observed in bed. She indicated everyone was nice to her. Resident L's clinical record was reviewed on 9/27/23 at 4:15 p.m. Diagnoses cognitive communication deficit, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Her medications included escitalopram oxalate (treat anxiety) 10 mg (mg) daily. A 6/3/23 quarterly MDS indicated she was cognitively intact. No behaviors were exhibited. She had a current behavioral care plan for refusal of treatment or care. As example by, refusal of care, medications, getting out bed, showers and brushing hair (revised on 9/18/23). Her interventions included converse with her to determine why she refused (3/6/23), converse with her during care to explain procedure (7/5/22), educate her regarding the importance of care and treatment to her health (7/5/22), have another staff member address her (7/5/22), offer another time for care (7/5/22) and provide positive reinforcement (7/5/22). Her clinical record lacked documentation of the incident with CNA 6. On 9/27/23 at 9:49 a.m., Resident K was observed sitting on the side of her bed. She indicated everyone was nice to her.		paraeid="{f8c357f3-429c-4d72-b3ce-40f64d3e7d38}{114}" > How be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ·After 8 weeks, the DON/ADON/Unit Managers/SDC/TCN or Clinical Consultant will continue to review the Facility Activity Report for any documented note that may warrant an investigation daily M-F. Any discrepancies found will be reported to the Regional Nurse Consultant or VP of Operations. Results of the audit will be reported to the QA committee weekly to determine the further need of continued education or revision of plan. At that time, based on evaluation, the QA committee will determine at what frequency the audit of controlled substances by management will need to continue. Concerns identified will be corrected immediately and reported to to ensure investigation of properly counting controlled substances audits are being conducted. A QAPI meeting was held on	

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	Resident K's clinical record was reviewed on 9/27/23 at 3:56 p.m. Diagnoses included cognitive communication deficit, generalized anxiety disorder, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Her medications included escitalopram oxalate 20 milligram daily and trazodone (treat depression) 50 mg daily. A 8/15/23 quarterly Minimum Data Set (MDS), indicated she was severely cognitively impaired. No behaviors were exhibited. Her clinical record lacked documentation of the incident with CNA 6. A 9/15/23 revised facility policy, titled "Abuse, Neglect and Misappropriation of Property," provided by the Administrator on 9/27/23 at 3:02 p.m., indicated the following: "...Verbal Abuse is the use of any oral, written or gestured language that includes any threat, or any frightening, disparaging or derogatory language, to residents or their families, or within their hearing distance, regardless of age, ability to comprehend, or disability...Allegation of Abuse: This means a report, complaint, grievance, statement, incident or other facts that a reasonable person would understand to mean that abuse, as defined in this policy, is occurring, has occurred, or plausibly might have occurred...E. Investigation Guidelines 1. The Facility Administrator will investigate all allegations, reports, grievances, and incidents that potentially could constitute "allegations of abuse,"...The Facility Administrator may delegate some or all of the investigation as appropriate, but the Facility Administrator retains the ultimate		9/27/2023 with the QAPI committee. Beginning the week of 10/2/2023, the QAPI committee will meet monthly throughout the audit for recommendations and further follow up regarding the above stated plan. The audit documentation will continue to be submitted to the monthly QAPI committee for review and to ensure ongoing compliance. The QAPI committee reserves the right to modify or extend monitoring times according to outcomes. The Administrator is responsible for the oversight of this plan to ensure ongoing compliance.	

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	responsibility to oversee and complete the investigation, and to draw conclusions regarding the nature of the incident...." 3.1-28(d)			