STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155793	A. BUILDING 00 B. WING	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMILTON TRACE OF FISHERS	11851 CUMBERLAND RD FISHERS, IN 46037

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00424343. This visit included a State Residential Licensure Survey. Complaint IN00424343- Federal/State deficiency related to the allegations is cited at F0755. Survey dates: March 5, 6, 7, and 8, 2024. Facility number: 012644 Provider number: 155793 AIM number: 201046710 Census Bed Type: SNF/NF: 54 SNF: 49 Residential: 67 Total: 170 Census Payor Type: Medicare: 39 Medicaid: 41 Other: 23 Total: 103 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 14, 2024	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after March 29, 2024. Hamilton Trace is requesting a face-to-face IDR. Hamilton Trace respectfully requests additional evidentiary information be considered in eliminating or reducing Federal Tag 684. The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the provider to its residents. Hamilton Trace respectfully requests additional evidentiary information be considered in eliminating or reducing Federal Tag 880. The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the provider to its residents.	

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

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F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review the facility failed to ensure accuracy of Minimum Data Set (MDS) assessments regarding restraint use and discharge location for 1 of 1 residents reviewed for Restraint use and 1 of 1 resident received for hospitalization . (Resident 5 and 106) Findings include: 1. The clinical record for Resident 5 was reviewed on 3/8/24 at 11:05 a.m. The diagnoses included, but were not limited to, dementia, impaired mobility, and cerebrovascular accident (CVA). A Quarterly MDS assessment, dated 2/15/24, indicated the chair prevents rising under the restraint section and it was utilized less than daily. There were no care plans for restraint use and/or physician orders for the utilization of a restraint. An Occupational Therapy (OT) note, dated 11/1/23, indicated the utilization of a pommel cushion but no restraint. An interview conducted with the Director of Nursing (DON), on 3/7/24 at 10:00 a.m., indicated the MDS for Resident 5 was miscoded and it was corrected. Resident 5 does not utilize any restraints. 2. The clinical record for Resident 106 was reviewed on 3/7/24 at 9:00 a.m. The diagnosis for Resident 106 included, but was not limited to,	F 0641	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? MDS assessment for resident 5 and resident 106 was corrected during the survey. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken Residents coded for restraint use and residents who discharge from the facility have the potential to be affected by the alleged deficiency. An audit for restraints was completed to ensure MDS accuracy. An audit of the discharges for the last 30 days was completed to ensure MDS accuracy. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur MDS associates educated regarding MDS accuracy. Education will occur upon hire and annually. 4 How the corrective action(s)	03/29/2024

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	thoracic vertebra (middle of spine) fracture. The discharge MDS assessment completed on 1/17/24 indicated the resident was discharged to an acute hospital. A nursing progress note dated 1/17/24 indicated Resident 106 was discharged home. An interview was conducted with the MDS Coordinator on 3/7/24 at 10:36 a.m. She indicated the discharge MDS assessment completed on 1/17/24 for Resident 106 was coded in error. It should have been marked as discharged to home. An interview was conducted with the Director of Nursing on 3/8/24 at 8:50 a.m. He indicated the facility did not have a policy regarding MDS accuracy. The facility follows the RAI (Resident Assessment Instrument) manual.		will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place DON or designee will audit MDS assessments for residents coded for restraint use and for residents discharged from the facility for accuracy. Audits will occur weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a gait belt was utilized during resident transfers and fall prevention measures were implemented during a residents' transfer that led to them being lowered to the ground for 1 of 6 residents reviewed for	F 0689	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 2 and resident 97 were provided gait belts for usage during	03/29/2024

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	ADL (Activities of Daily Living) and 1 of 3 residents reviewed for accidents. (Resident 2 and 97) Findings include: 1. The clinical record for Resident 97 was reviewed on 3/7/24 at 11:43 a.m. The diagnoses included, but were not limited to, spinal stenosis, anemia, dysphagia, weakness, lack of coordination, and mixed receptive-expressive language disorder. An Admission Minimum Data Set (MDS) assessment, dated 1/16/24, indicated he was cognitively intact, had impairment to one side of the upper extremities, partial/moderate assistance with sit to standing, and partial/moderate assistance with chair/bed-to-chair transfer. An interview conducted with Resident 97, on 3/7/24 at 10:15 a.m., indicated he had fallen a couple of days prior to the interview. The "CNA" (Certified Nursing Aide) came in and they didn't utilize a gait belt. A gait belt was observed to be folded and located on top of the air conditioning/heat unit in his room. Resident 97 indicated that gait belt had not been utilized "in over a month". The CNA held underneath his right arm while he stood upwards. His wheelchair was not locked on one side and when he attempted to sit down the wheelchair moved back while he attempted to sit down. He also had no footwear on and indicated the floor was "slippery" when he doesn't wear any non-skid footwear due to callouses on his feet. He was then lowered to the floor by the nursing staff. An event report, dated 3/3/24, indicated Resident 97 fell next to his bed, wheelchair was in use, and the fall was assisted.		transfers. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken Residents requiring assistance with transfers have the potential to be affected by the alleged deficient practice. An audit was completed to ensure gait belts are available for use during transfers. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Nursing associates educated on the use of gait belts for transfers for residents requiring assistance. Associates will be educated upon hire and annually. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place DON or designee will observe 5 transfers to ensure gait belts are being used for residents who require assistance. Audits will occur daily x 30 days, then weekly x 12 weeks, then monthly for 5 months. The results of these reviews will be discussed at the monthly facility Quality Assurance	

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	A progress note, dated 3/3/24 at 11:00 a.m., indicated the following, "...summoned to resident room via CNA on duty. Upon entering, resident was noted sitting on floor next to bed. CNA on duty stated she had to guide resident to the floor as he became unsteady during transfer from bed to w/c [wheelchair]...." A fall care plan, edited 3/5/24, indicated Resident 97 was at risk for falling and fall related injuries related to required assistance from staff for transfers, utilized wheelchair, history of falls, and had an indwelling catheter in place. The approaches included, but were not limited to, assist of 1-2 staff with transfers, assistance with activities of daily living (ADLs) to meet needs, and encourage resident to wear gripper socks when out of bed if shoes are not worn (added on 3/8/24). An interview with the Director of Nursing (DON), on 3/7/24 at 10:20 a.m., indicated he believed there were students in Resident 97's room at the time of the fall event and they did not have the items in place when transferring Resident 97. An interview with the DON, on 3/8/24 at 11:00 a.m., indicated he added gripper socks to Resident 97's plan of care. An interview with the DON, on 3/8/24 at 12:22 p.m., indicated there was no facility policy on the utilization of a gait belt. 2. The clinical record for Resident 2 was reviewed on 3/6/24 at 10:50 a.m. The Resident's diagnosis included, but were not limited to, multiple sclerosis and dementia. A care plan, initiated 11/17/22, indicated that		Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	

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	Resident 2 was at risk for falls related to needing assistance of staff with transfers. The goal was for the risk for falls and fall related injuries to be minimized. The interventions included, but were not limited to, assist with ADLs to meet needs, initiated 11/17/23, observe for and report any functional changes, initiated 11/17/23, and call don't fall sign added to the room, initiated 12/5/23. On 3/6/24 at 10:50 a.m., Resident 2 was observed being transferred from her wheelchair to her recliner chair in her room. CNA (Certified Nursing Assistant) 3 positioned the wheelchair close to the recliner. CNA 3 then put her hands on either side of Resident 2 just under her armpits and lifted Resident 2, pivoting with her and sat Resident 2 into her recliner chair. No gait belt was used. Resident 2 had a slight grimace on her face during the transfer. A sign was observed posted by Resident 2's door which read " Helping [Resident 2] move lift with gait belt not arms or shoulders to standing use walker. She pivots with walker, lower to next seat with gait belt". A gait belt was hanging on a hook behind the door. Resident 2 indicated that the staff sometimes used the gait belt. During an interview on 3/08/24 at 1:43 p.m., the TM (Therapy Manager) indicated that Resident 2 had decreased range of motion in her shoulder. A gait belt was important to use for safety when transferring residents, especially with Resident 2. The Indiana State Department of Health Nurse Aide Curriculum, revised November 19, 2015, indicated the following, "...PROCEDURE #24: USING A GAIT BELT TO ASSIST WITH AMBULATION...3. Place belt around resident's waist with the buckle in front and adjust to a snug fit ensuring that you can get your hands under			

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	the belt...4. Assist the resident to stand on count of three...6. Stand to side and slightly behind resident while continuing to hold onto belt...PROCEDURE #26: TRANSFER TO WHEELCHAIR...2. Place wheelchair on resident's unaffected side...4. Stand in front of resident and apply gait belt around the resident's abdomen...." 3.1-45(a)(2)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable			

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	an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to timely administer an antibiotic, as ordered by the physician, to ensure physician orders were followed regarding administration of duplicate medication therapy for an antidepressant for 2 of 6 residents reviewed for unnecessary medications (Resident B and C). Findings include: 1. The clinical record for Resident B was reviewed on 3/5/24 at 2:53 p.m. The Resident's diagnosis included, but were not limited to, diabetes and urinary tract infection. She was admitted to the rehab unit of the facility on 12/15/23. A care plan, initiated 12/18/23, indicated Resident B had a urinary tract infection. The goal was for her not to exhibit signs of urinary tract infection upon completion of antibiotics. The interventions included, but were not limited to, administer antibiotic per order, initiated 12/18/23, and assist with incontinence care, initiated 12/28/23. A physician's order, dated 12/15/23, indicated she was to receive linezolid (antibiotic) 600 mg (milligram) 1 tablet every 12 hours. The order was discontinued on 12/18/23. A physician's order, dated 12/18/23, indicated she was to receive linezolid 600 mg 1 tablet every 12 hours. The order was discontinued on 12/19/23.	F 0755		

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	A physician's order, dated 12/19/23, indicated she was to receive linezolid 600 mg 1 tablet every 12 hours through 12/21/23. The December 2023 MAR (Medication Administration Record) indicated that the linezolid 600 mg, ordered 12/15/23, was not administered on 12/15/23 due to pharmacy delivery, 12/16/23 due to being unavailable, 12/17/23 due to allergy and drug unavailable, and 12/18/23 the medication was discontinued. The linezolid was reordered on 12/18/23 and was documented as given on 12/18/23 at 1:00 p.m., and as not given due to being unavailable on 12/19/23 at 1:00 a.m. The linezolid, ordered 12/19/23 was documented as administered as ordered from 12/19/23 at 6:00 a.m. through 12/21/23 at 6:00 a.m. During an interview on 3/7/24 1:45 p.m., FM (Family Member) 5 indicated that Resident B did not receive her antibiotics timely after being admitted to the rehab unit. Resident B was admitted to the rehab unit on Friday 12/15/23 with an order to receive an antibiotic. Resident B did not receive the antibiotic until Monday 12/18/23. FM 5 had been told it was due to an allergy that was listed in Resident B's record. The facility had not contacted FM 5 about the delay in Resident B receiving her antibiotic until 12/18/23, when FM 5 informed the facility that Resident B had tolerated the linezolid in the past and it was not an allergy. During an interview on 3/8/24 at 10:53 a.m., Pharmacy Tech 6 indicated the pharmacy had received an order for Resident B to receive linezolid on 12/15/23. Resident B had an allergy for linezolid list in her medical record and a drug regimen review had been sent to clarify the order. The linezolid would not have been sent by the pharmacy until the order was clarified. The			

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	linezolid 600 mg had been dispensed on 12/18/23. During an interview on 3/8/24 at 11:03 a.m., the Director of Nursing indicated Resident B had been admitted on a Friday evening. Linezolid was listed as an allergy, but she had tolerated the medication in the past, so the pharmacy was contacted the following Monday. FM 5 had been informed about the allergy on Monday 12/18/23. 2. The clinical record for Resident C was reviewed on 3/7/24 at 3:20 p.m. The diagnoses included, but were not limited to, chronic kidney disease, anxiety disorder, and depression. A physician order, dated 10/2/23, was noted for Wellbutrin SR (sustained release) tablet; 100 milligrams; twice a day from 10/2/23 to 10/6/23. A physician order, dated 10/3/23, was noted for bupropion (generic name for Wellbutrin) tablet; 100 milligrams; twice a day from 10/3/23 to 10/11/23. A pharmacy recommendation, dated 10/6/23, indicated a duplication of therapy and the recommendation to discontinue the order for bupropion tablet 100 milligrams or Wellbutrin tablet 100 milligrams. The electronic medication administration record (EMAR) for October of 2023, indicated the bupropion and Wellbutrin 100 milligrams were administered, as duplicate therapy, on 10/3/23 in the evening, 10/4/23 in the morning and evening, 10/5/23 in the evening, and 10/6/23 in the morning. On 3/8/23 at 2:55 p.m., the Director of Nursing provided the current Medication Administration: General Policies & Procedures which read "...Medications are administered as prescribed in accordance with good nursing principles and			

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	practices..." 3.1-32(a) 3.1-35(a) 3.1-35(b) This Federal tag relates to Complaint IN00424343.			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or			

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	infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			

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	Based on observation and record review, the facility failed to maintain an infection prevention and control program by not ensuring a urinary catheter's tubing was off of the floor for 1 of 2 residents reviewed for a urinary catheter. (Resident 89) Findings include: The clinical record for Resident 89 was reviewed on 3/7/24 at 9:58 a.m. Resident 89's diagnoses included, but not limited to, urinary tract infection, atrial fibrillation (irregular heartbeat), sacral pressure ulcer stage III, and obstructive and reflux uropathy (difficulties in urination). A Brief Interview for Mental Status (BIMS) assessment completed on 3/6/24 indicated Resident 89 was cognitively intact. An observation of Resident 89 on 3/5/24 at 11:30 a.m. found Resident 89 asleep in his bed and his urinary bag and tubing were lying on the floor. An observation on 3/7/24 at 1:38 p.m. found Resident 89 asleep in his bed with his Foley catheter bag and tubing lying on the floor. Resident 89's care plan dated 1/9/24 indicated, Resident 89 required an indwelling urinary catheter related to obstructive uropathy. One of the interventions indicated, "Do not allow tubing or any part of the drainage system to touch the floor." A Catheterizing The Urinary Bladder with an Indwelling Catheter Skills Validation received on 3/7/24 at 3:42 p.m. indicated, "For a Male Residents...18. Position the drainage bag below the level of the bladder at the side of the bed *no	F 0880	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 89 no longer resides in the facility. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken Residents with urinary catheters have the potential to be affected by the alleged deficient practice. An audit was conducted to ensure urinary tubing was not touching the floor. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Nursing associates educated to ensure urinary tubing does not touch the floor. Education will occur upon hire and annually. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place DON or designee will observe residents with urinary catheters to ensure tubing does not touch the floor. Audits will occur daily x 30 days, weekly x 12 weeks, then	03/29/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155793	A. BUILDING 00 B. WING	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	tubing must touch the floor." 3.1-18(a) 3.1-18(b)		monthly for 5 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00424343 Complaint IN00424343- Federal/State deficiency related to the allegations is cited at F0684. Survey dates: March 5, 6, 7, and 8, 2024 Facility number: 012644 Residential Census: 67 Hamilton Trace of Fishers was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on March 14, 2024	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after March 29, 2024. Hamilton Trace is requesting a face-to-face IDR. Hamilton Trace respectfully requests additional evidentiary information be considered in eliminating or reducing Federal Tag 684. The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the provider to its residents. Hamilton Trace respectfully	

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			requests additional evidentiary information be considered in eliminating or reducing Federal Tag 880. The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the provider to its residents.	