STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE CENTER	333 W MISHAWAKA RD ELKHART, IN 46517

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00352215. Complaint IN00352215 - Substantiated. No deficiencies related to these allegations are cited. Survey dates: May 2, 3, 4, 5, 6 & 7, 2021 Facility number: 000523 Provider number: 155496 AIM number: 100266930 Census Bed Type: SNF/NF: 89 Total: 89 Census Payor Type: Medicare: 2 Medicaid: 78 Other: 9 Total: 89 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on May 17, 2021.	F 0000		
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2)			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, interview and record	F 0656	F- 656 COMP. Care Plans	06/06/2021

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	review, the facility failed to ensure care plans were individualized to resident needs for 3 of 33 residents whose care plans were reviewed. (Residents 7, 24 & 61) Findings include: 1. A record review was conducted, on 5/05/21 at 1:00 P.M., for Resident 7 and indicated his diagnoses included, but were not limited to, alcohol abuse, cognitive communication, subdural hemorrhage, altered mental status and schizophrenia. A quarterly MDS, dated 1/26/21, indicated Resident 7 had severe cognitive impairment a diagnoses of schizophrenia and had received an antipsychotic for 7 days of the look back period. A psychiatry progress note, dated 4/8/21, indicated Resident 7 received Latuda 40 mg 1 tablet by mouth one time daily related to schizophrenia and was delusional. Behavior sheets, dated February 2021, March 2021, April 2021 and May 1-5, 2021, indicated his behaviors were delusions, hallucinations and self isolated, but were not resident specific. A care plan, dated 10/6/2020, indicated Resident 7 had a mood problem related to disease process schizophrenia, but did not specify what mood problems he had related to his schizophrenia with resident specific interventions. During an interview, on 5/06/21 at 10:56 A.M., the DON (Director of Nursing) indicated Resident 7 has delusions about being able to go home and have a house.		1. Resident 7's care plan has been revised to include his mood problem related to disease process Schizophrenia to include what mood problems he has related to his schizophrenia with specific interventions. Resident 24's care plan has been revised to include individualized activity preferences and bowel plan has been individualized. Resident 61's care plan has been individualized to her behavioral needs. 2. All residents have the potential to be affected. An audit will be completed of all residents' for activity preferences, bowel plans, and mood and behavioral needs to validate the care plan has been revised with individualized interventions in congruence with each resident's preferences. 3. The DON, MDS coordinator, social services director, and all members of the IDT have been in-serviced on developing the comprehensive care plan. 4. The DON/Designee will audit 4 care plans a week for accuracy in providing resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. All Care plans will be resident specific/resident focused and reflect	

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	During an interview, on 5/06/21 at 11:46 A.M., QMA (Qualified Medication Aide) 20 indicated sometimes Resident 7 talks about space people and striking oil. 2. A clinical record review was conducted on 5/5/2021 at 12:17 P.M., and indicated Resident 24's diagnoses included but were not limited to: aspiration pneumonia, anoxic brain damage, brain stem stroke and quadriplegia. On 5/3/2021 at 1:26 P.M., Resident 24 was observed lying in bed with no activities occurring. On 5/5/2021 at 10:55 A.M., Resident 24 was observed lying in bed with no activities occurring. Resident 24 was not observed in any activities during the survey process. A care plan, dated 10/1/2020, indicated Resident 24 "...is dependent on staff for activities, cognitive stimulation, social interaction r/t immobility...." Interventions documented were "...Provide a program of activities that is of interest...", "...Provide with activities calendar...." and "....Thank resident for attendance at activity function...." A care plan, dated 3/4/2021, indicated Resident 24 "...The resident has little or no activity involvement Disease Process...." Interventions documented were: "...Assist with transport to activities as needed....", "...Assure that the activities are compatable with resident?s physical and cognitive capabilities....", Ensure all snacks / beverages comply with all diet / fluid restrictions....", "...Provide 1:1 in room visits if		resident/representative opportunities for participation and preferences. This audit will be completed weekly for 12 weeks and all findings will be reported to the QAPI Committee monthly. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is to be continued.	

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unable to attend out of room events...." and "...Provide aromatherapy...."

During an interview, on 5/5/2021 at 11:06 A.M., the Activity Director indicated Resident 24's care plan was not individualized to Resident 24.

A care plan, dated 10/1/2020, indicated Resident 24 "...has bowel incontinence r/t immobility, inability to delay urge to void, persistent vegetative state, and dx of stroke and quadriplegia...." Interventions included: "...Observe pattern of incontinence, and initiate toileting schedule if indicated...."

During an interview, on 5/10/2021 at 2:00 P.M., the DON (director of nursing) indicated Resident 24's bowel care plan was not reflective to their individualized needs.

3. A clinical record review was conducted on 5/3/2021 at 1:08 P.M., and indicated Resident 61's diagnoses included but were not limited to: cerebral infarction, delusional disorders and dementia.

A nurses note, dated 3/20/2021 at 8:40 P.M., indicated "... Nurses Note Note Text: Res. refused some medications during the shift. She also refused dinner and snacks. Res. was noted talking and screaming at people who were not in the room. She was aggressive and hit CNA's during care. Res. denies pain or discomfort. She was difficulty to redirect...."

A behavior note, dated 3/27/2021 at 2:00 P.M., indicated "...Resident has had an increase in behaviors this shift. She has been having more hallucinations and delusions. Seeing people who are not in room and having conversations with

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	people who are not in room. Removing gown and sheet and laying in bed naked but denying she was naked...." A behavior note, dated 3/28/2021 at 1:12 P.M., Indicated "...Continues to pull off her shirt or gown or sheet and laying in bed naked. Resident states she is not naked...." A behavior note, dated 4/6/2021 at 9:12 A.M., indicated "...resident refused to take her meds this am because she was tired. Attempted to give them later and she put them in her mouth then spit them out stating they weren't her meds. Could not convince her otherwise. Will try again later...." A behavior note, dated 4/6/2021 at 1:59 P.M., indicated "...Went into resident's room and noted her lunch tray was on the floor. Asked the resident what happened and she stated she was done eating, so I replied, So, you pushed it on the floor? She stated, I was making room for the large group of people coming in my window. Resident still hallucinates and is delusional...." A care plan, dated 2/15/2021, indicated "...Diana has a behavior problem: history of false allegations that roommate is stabbing her, hallucinating person named "Joy", who is also stabbing her...." Interventions documented were: "...Administer medications as ordered. Observe and document s /sx of effectiveness and side effects. Educate resident / resident representative to mediation effectiveness and side effects....", "...Approach, speak in calm manor....", "...Behavioral health consults as needed....", "...Communicate with resident / resident representative regarding behaviors, and treatment....", "...Consult with Pastoral care,			

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	Psych services, and/or support groups....", "...Encourage active support by family / resident representatives....", "...Monitor behavioral episodes, and attempt to determine underlying causes...." and "...Notify medical provider of increased episodes of behaviors...." During an interview, on 5/10/2021 at 2:00 P.M., the DON indicated Resident 61's care plan was not individualized to her behavioral needs.A policy was provided by the DON, on 5/7/21 at 2:49 P.M., titled, "Plan of Care Overview", revised 7/26/2018, and indicated the policy was the one currently being used by the facility. The policy indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. III b. Care plan documents are resident specific/resident focused and reflect resident/representative opportunities for participation and preferences...." 3.1-35(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review and interview, the facility failed to have the appropriate plan of care related to how a resident received dialysis and failed to complete assessments before and after dialysis on a resident who required dialysis for 1 of 1 residents reviewed for dialysis. (Resident 84)	F 0698	F-698 Dialysis 1. Resident 84’s care plan for dialysis has been revised to include how dialysis is administered. Resident 84 has a pre and post dialysis assessment implemented.	06/06/2021

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	Finding included: During an interview and observation, on 5/5/21 at 3:30 P.M., Resident 84 indicated she has a fistula to her right arm and does not have a catheter to her upper left chest. She pulled up her sleeve to show her fistula and pulled down her shirt to show where the catheter used to be in her upper left chest. A record review was conducted, on 5/05/21 at 3:00 P.M. for Resident 84 and indicated her diagnoses included, but not limited to, end stage renal disease, type 2 diabetes mellitus with diabetic chronic kidney disease and dependence on renal dialysis. A Quarterly MDS (Minimum Data Set) assessment, dated 4/22/21, indicated she was cognitively intact and had a diagnoses of end stage renal disease. A physician's orders, dated 3/16/21, indicated an order for Resident 84 for dialysis log vital signs and weight every Tuesday, Thursday and Saturday for dialysis monitoring (weight on dialysis day should be post-dialysis dry weight). A progress note, dated 7/17/20, indicated she was coming back from the hospital and facility was given instructions regarding her AV (Arteriovenous) fistula graft. A care plan, dated 10/6/2020, indicated Resident 84 received hemo dialysis and was at risk for complications. Care plan interventions, dated 10/6/2020, indicated Resident 84 went to dialysis on		2. An audit will be completed of all residents who receive dialysis to validate their care plan is current with the site for administration of dialysis and a pre and post assessment are completed. 3. Education will be completed with the MDS coordinator, all licensed nurses, and the clinical management team on Hemodialysis Care and Monitoring and revising care plans. 4. The DON/Designee will audit all residents receiving dialysis medical record 3 times a week for 12 weeks to validate the Pre and Post dialysis assessments are completed. The DON/Designee will audit the care plans of all residents receiving dialysis monthly and with change of dialysis site to validate the care plan has been revised to reflect the accuracy of the location of the dialysis site is accurate in the care plan. This audit will be completed weekly for 12 weeks and all findings will be reported to the QAPI Committee monthly. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is to be continued.	

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Tuesday, Thursday and Saturday and had a chest catheter. It indicated to obtain vital signs and weight per protocol and to report significant changes in pulse, respirations and blood pressure immediately, to monitor for signs and symptoms of fluid or electrolyte imbalance, to monitor/document for peripheral edema and ascites and notify physician if identified.

There was not a care plan present for Resident 84 having an AV fistula.

There were no dialysis assessments completed for before and or after dialysis for February 4, 9, 13, 18, 23 and 25, 2021, for March 4, 9, 16 and 23, 2021 and for May 4, 2021.

During an interview, on 5/07/21 at 11:15 A.M., the DON indicated there should be a dialysis assessments completed before and after Resident 84 goes to dialysis.

During an interview, on 5/07/21 at 3:22 P.M., the ED (Executive Director) indicated Resident 84's care plan should have been updated when she received the AV fistula.

A policy was provided by the DON, on 5/7/21 at 2:49 P.M., titled, "Hemodialysis Care and Monitoring", revised 3/23/2018, and indicated the policy was the one currently being used by the facility. The policy indicated "....Pre-Dialysis a. Evaluation completed within four (4) hours of transportation to dialysis to include but not limited to: i. accurate weight, ii. Blood Pressure, Pulse, Respiration and Temperature b. Medications administered or medication(s) withheld prior to dialysis...Post-Dialysis b. nurse to complete the post-dialysis evaluation upon return from dialysis center to include but

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	not limited to: i. thrill absence or presence ii. Bruit absence or presence iii. Pulse in access limb...iv. Blood pressure, pulse, respiration and temperature upon return to facility, v. Visual inspection of site for bleeding, swelling, or other abnormalities...." 3.1-37(a)			
F 0744 SS=E Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to provide appropriate and individualized dementia care and services to support psychosocial well-being for 5 of 5 residents reviewed for dementia care. (Resident 30, Resident 3, Resident 48, Resident 54, and Resident 81) Findings include: On 5/2/21 at 11:30 A.M., the secured memory care unit was observed. There were no activities occurring and residents were observed in their rooms, wandering in the hallways, or seated in the dining room. The common area/living area was a small room with windows to the hallway and 2 doors. A TV set was on and 1 resident sat in the room and appeared to be sleeping with his eyes closed. There were no clocks on the wall and a large wall calendar hanging next to the TV indicated the day was April 21, 2021 and the weather was cold outside.	F 0744	F 744 Treatment/Service for Dementia 1. Resident 30, Resident 3, Resident 48, Resident 54, and Resident 81's care plans have been revised to provide appropriate and individualized dementia care and services to support psychosocial well-being. 2. An audit will be completed of all residents care plan residing on the secured unit for revisions needed to be in accordance with ongoing reviews of care plan goals and interventions to ensure they reflect the need to correct or compensate for behavioral concerns including safety of self and others. An audit of the secured Unit to validate activities are designed for cognitively impaired residents and are	06/06/2021

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	1. On 5/5/21 at 9:27 A.M., the record for Resident 30 was reviewed. Diagnoses included, but were not limited to, dementia without behavioral disturbance, anxiety disorder, delusional disorder, and recurrent depressive disorder. He resided on the secured memory care unit. A quarterly MDS (Minimum Data Set) assessment, dated 1/22/21, indicated the resident had severely impaired cognition. He had physical and verbal behaviors 1-3 days of the assessment and wandered 4-6 days. On 5/03/21 at 10:15 A.M., Resident 30 was observed seated out in the dining room eating a bowl of cold cereal. There were no other residents present. The nurse who was present, indicated the resident liked to sleep in and eat breakfast late. On 5/5/21 at 12:30 P.M., the resident was observed wandering around and out one door of the dining room and coming back in the other several times. He wore a frown on his face and appeared distressed as he walked quickly around the dining area. Staff were present and were passing out lunch trays. Nurse notes indicated the resident had been involved in 2 negative interactions with another resident which were as follows: On 3/25/21 at 6:48 p.m., another resident had been observed to push Resident 30 from behind which caused the resident to lose his balance and fall onto his hands and knees. On 5/1/21 at 8:27 p.m., Resident 30 was slapped on the back with an open hand by another resident		included to decrease boredom and provide an outlet for expression. The facility will identify and safely manage residents who are exhibiting behaviors related to psychiatric diagnoses or who may present a danger to themselves or others. Residents will be provided with a resident centered behavior management plan. A Complete Care Plan-update with changes and/or new behaviors, involving social service and activities department with resident specific interventions. 3. Education will be completed with the IDT team and all staff assigned to the secured unit on care plans for residents residing on the secured unit to include revisions needed to be in accordance with ongoing reviews of care plan goals and interventions to ensure they reflect the need to correct or compensate for behavioral concerns including safety of self and others. Education will be included on activities on the secured unit to validate activities are designed for cognitively impaired residents and are included to decrease boredom and provide an outlet for expression. The facility will identify and safely manage residents who are exhibiting behaviors related to psychiatric diagnoses or who may present a	

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	when exiting the dining room. The resident was moving his chair around the table when the other resident approached and slapped him. A Psychiatry Initial Consult progress note, dated 1/28/21 at unknown time, indicated the resident had been seen for concerns with mood, behavior, and current psychotropic medications. The resident was reported to be uncooperative with nursing staff, verbally aggressive, resisted care, and cursed at staff. The plan was for staff to provide supportive care and appropriate behavioral interventions. Psychiatry progress notes, dated 3/11/21 and 4/29/21, indicated the resident had periods of agitation but was redirectable. The plan was to continue with supportive care and appropriate behavioral interventions. The progress notes did not indicate the resident had been involved in an incident with another resident who had pushed him down. A MAR (Medication Administration Record) for April and May 2021, indicated the following behaviors were being monitored each shift for depression and use of antipsychotic medications: tearfulness, being withdrawn, change in appetite, delusions, hallucinations, and agitation. The MAR did not indicate behaviors of verbal aggression, resisting care or cursing at staff was being monitored. Care plans indicated Resident 30 was at risk for decline in his psychosocial well-being, mood problems due to anxiety and dementia, use of anti-psychotic medication for behavior management, and required a secured unit due to behaviors and elopement risk. Interventions included, but were not limited to, provide visible		danger to themselves or others. Residents will be provided with a resident centered behavior management plan. A Complete Care Plan-update with changes and/or new behaviors, involving social service and activities department with resident specific interventions. 4. The DON/Designee will audit all residents care plans residing on the secured unit weekly for 12 weeks to validate revisions are current with individualized interventions for activities and behaviors. The ED/Designee will observe activities on the secured unit 3 times a week for 12 weeks to validate activities are implemented and validate activities are designed for cognitively impaired residents and are included to decrease boredom and provide an outlet for expression. This audit will be completed weekly for 12 weeks and all findings will be reported to the QAPI Committee monthly. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is to be continued.	

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	clocks and calendar; when conflict arise, remove residents to a calm and safe environment and allow to vent/share feelings; administer medications as ordered; behavioral health consults as needed; encourage resident to voice feelings, and discuss coping skills; provide a calm environment, limit over-stimulation; provide a program of activities that accommodates abilities; and provide diversionary activities as needed and redirect when appropriate. The care plan did not indicate the resident had hallucinations nor did it address the resident's risk for being the target of another resident's behaviors. The care plan was not specific for activities the resident enjoyed and was able to participate in nor did it address the effect his behaviors could have on others in the unit and interventions for prevention. 2. On 5/05/21 at 10:58 A.M., the record for Resident 3 was reviewed. Diagnoses included, but were not limited to, vascular dementia with behavioral disturbance, delusional disorder, and recurrent severe major depressive disorder. A quarterly MDS assessment, dated 1/22/21, indicated the resident had severely impaired cognition. During the assessment, he had wandered 1-3 days and had no behaviors. On 5/5/21 at 12:10 P.M., Resident 3 was observed standing in the far corner of the dining room shifting his weight from foot to foot. He was observed to be talking to the ladies seated at a nearby table as he lifted his hand to try and get the attention of staff who were passing out lunch trays. He walked to the middle of the room and told the CNA (Certified Nurse Assistant) that he had to toilet. He was assisted out of the dining room and later returned to eat his lunch.			

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Nurse notes indicated the resident had been involved in altercations with staff and other residents on the following days:
-12/16/2020 at 8:18 a.m., Resident 3 punch a staff member who was attempting to assist him to get dressed.
-12/26/2020 at 8:00 p.m., Resident 3 and another male resident were observed standing in the lounge. Resident 3 pushed the other resident in the chest which caused him to fall on the floor in a sitting position. Staff had reported Resident 3 had been agitated throughout the day. The resident was sent out to the emergency room for evaluation on 12/28/20. He returned to the facility on 12/29/21 without new orders.
-3/22/21 at 1:53 p.m., Resident 3 was observed seated in the common room next to a female resident who sat in her wheelchair. A third resident observed Resident 3 slap the female resident on her left cheek and then got up and left the room. There were no injuries noted on the female residents face and the resident was unable to tell staff what happened. Resident 3 was placed on 1:1 monitoring.
-On 3/25/21 at 6:48 p.m., Resident 3 had been observed to push a male peer from behind which caused the resident to lose his balance and fall onto his hands and knees. The staff questioned the residents ability to see well and made a eye appointment for the resident which was scheduled for May 2021.
-On 5/1/21 at 8:27 p.m., Resident 3 was observed to slap a male peer on his back with an open hand when both were exiting the dining room.

Psychiatry progress notes, dated 12/17/20, indicated the resident was seen for concerns with his mood and behaviors. Prior to admission, he

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	had been hospitalized at a neurobehavioral hospital due to delusions, agitation, confusion, and threatening to hit others. He had a history of anger issues and impulsiveness. The resident had some agitation and aggression at times since admission. Staff were to continue with his current medication regimen and provide supportive care and appropriate behavioral interventions. The resident was seen again on 12/30/20 following his aggression towards another resident and trip to the emergency room. He kept to himself but could become agitated at times, often unprovoked. The plan was to continue his current medications and behavioral interventions. Psychiatry progress notes for 1/7/21, 2/4/21, and 4/8/21, indicated the resident was seen for rechecks of his mood and behaviors. There were no changes made to his medications or behavioral plan. A MAR for April and May 2021, indicated the following behaviors were being monitored each shift for depression and anxiety: tearfulness, being withdrawn, change in appetite, anxiety, restlessness, and agitation. Care plans indicated the resident had impaired cognitive function due to dementia, used an antidepressant medication for depression, was at risk for mood issues due to delusional disorder and at risk for psychosocial distress due to negative interactions with other residents, used antianxiety medication for anxiety, wandered, had impaired social interactions, and was at risk for elopement. Interventions included, but were not limited to, provide a program of activities that accommodates abilities; provide visible clocks and calendar; encourage the resident to voice his feelings and discuss coping skills; provide a calm environment and limit over-stimulation;			

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administer medications as ordered; behavioral health consults as needed, and provide diversionary activities as needed and redirect when appropriate. The care plan did not indicate the resident could strike out at other residents either when provoked or not provoked and interventions to use to prevent altercations. The care plan did not have a specific behavior plan for the residents behaviors of agitation, anxiety, impulsitivity, irritability or physical aggression.

3. On 5/5/21 at 3:01 P.M., the record for Resident 48 was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease and major depressive disorder. The resident resided on the secured memory care unit.

A admission MDS assessment, dated 12/23/20, indicated the resident had severely impaired cognition. He had no mood or behavior issues.

On 5/5/21 at 10:30 A.M., the administrator completed a Indiana State Department of Health Reportable form which indicated an incident had occurred between 2 residents on the secured memory care unit. A female resident (Resident 38) had been in her room when Resident 48 came into her room and picked up 2 items of clothing off her bed and began to walk out of the room with them. The female resident began to yell at Resident 48 who allegedly made "unwanted physical contact" with her. The residents were separated and head to toe assessments completed on each resident. Both residents were placed on 72 hour psychosocial distress monitoring and the physician and families were notified of the incident.

On 5/5/21 at 12:16 P.M., Resident 48 was observed seated in the dining room across the

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	room from Resident 38 who was observed watching him from her table. He got up several times to change seats at the table and attempted to leave the dining room. He was reminded to sit down and he would be served his tray soon. Resident 38 was overheard telling her table mate that Resident 48 had "whipped me with my pants" when he had come into her room and picked up her clothing off the bed. Nurse notes indicated the following behaviors: -3/12/21 at 8:53 p.m., the resident was opening the ice cart and took the scoop out and had a stack of styrofoam cups in his hands. He became angry when he was redirected away from the ice cart and threw the stack of cups onto the floor. -3/25/21 at 10:24 a.m., resident was upset at breakfast when he was asked not to get into the ice. He got upset and threw the ice at staff and then walked away. Staff were to continue to monitor his mood and behaviors. -5/1/21 at 6:00 p.m., staff heard yelling in the hallway and found Resident 48 trying to pull another resident's walker away from him. The other resident yelled and pulled back on his walker. Resident 48 let go which caused the other resident to fall back onto the floor. The resident was directed away from the area. A MAR for April and May 2021 indicated the resident was monitored for behaviors of tearfulness, being withdrawn, and decrease in appetite due to depression. Care plans indicated the resident had impaired cognitive function due to dementia and was at risk for mood problem related to major depressive disorder. Interventions included, but were not limited to, encourage the resident to express his feelings; encourage participation in			

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	activities; provide a program of activities that accommodates abilities; provide visible clocks and calendar; provide antidepressant medication; provide a calm environment, limit over stimulation; and observe for behaviors. The care plan did not indicate the resident had issues with anger and interventions to prevent negative interactions with others. On 5/5/21 at 3:13 P.M., interviews were completed with staff who worked on the secured memory care unit and indicated the following: -LPN 97 (Licensed Practical Nurse)-indicated Resident 48 did have periods of anger which would cause him to pace and have an angry expression on his face. She indicated she would try to divert his attention or sit down with him when he had these behaviors. When questioned, she indicated she wasn't sure what other behavioral interventions there were for the resident but would expect to find them on the care plan. -QMA 25 (Qualified Medication Aide)-indicated when Resident 48 had behaviors of anger, it usually meant he was tired and would be assisted to bed. She indicated information for managing his behaviors would be found in the care plan. -CNA 15 (Certified Nursing Assistant)-indicated when the resident had behaviors, he would divert his attention with activities such as sweeping the floor which the resident enjoyed doing after meals. 4. On 5/5/21 at 11:10 A.M., the record for Resident 54 was reviewed. Diagnoses included, but were not limited to, dementia without behavioral disturbance. An admission MDS assessment, dated 2/14/21, indicated the resident had severely impaired			

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	cognition. She ambulated without assistance and had no wandering or other behaviors. A CAA (Care Area Assessment) for cognitive loss, dated 2/14/21, indicated the resident was at risk for further decline in cognition. Interventions included communication tools, allowing resident adequate time to process and respond, monitoring for decline in cognition, and therapy. A quarterly MDS assessment, dated 3/19/21, indicated the resident wandered 4-6 days during the assessment. Care plans indicated Resident 54 had impaired cognition, was at risk for decline in psychosocial well-being, was an elopement risk, was at risk for depression related to new admission to the facility and recent loss of spouse and was at risk for impaired social interactions. Interventions included, but were not limited to, keep her routine as consistent as possible in order to decrease confusion; provide a program of activities that accommodates abilities; provide visible clocks and calendar; when conflicts arises, remove residents to a calm safe environment and allow to vent/share feelings; assess for hunger, thirst, ambulation, and toileting needs. The following observations were made of Resident 54: -5/2/21 at 12:12 P.M., Resident 54 was observed seated in the dining room waiting for lunch. She sat at a table by herself next to a window. She got up and went into the hall to ask what she was supposed to be doing. -5/3/21 at 1:10 P.M., Resident 54 was observed several times wandering throughout the hallway			

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	of the unit. She asked staff frequently what she should be doing. She appeared anxious and tense and wore a frown on her face with furrowed eyebrows. She was observed shifting her weight from foot to foot while she stood and spoke to staff. -5/5/21 at 12:10 P.M., the resident was observed seated at her table in the dining room. She appeared nervous and tense with a frown on her face. She appeared to be watching a male resident who was standing near her who appeared tense and uncomfortable. Nurse notes indicated the following: -4/3/21 at 10:03 p.m., the resident is normally a nervous person and frequently checks with nursing staff for reassurance with anything she does. She was unusually nervous this evening and became agitated and confused when told it was time for bed. -4/7/21 at 1:24 p.m., resident is more anxious, pacing around the unit and walking in and out of her room multiple times. She was redirected multiple times. -4/9/21 at 7:11 p.m., the resident is constantly anxious and frequently asking staff permission to do just about everything. Resident stated "I'm afraid to cause any trouble". Staff tried to reassure her but she continued to pace nervously and asked where to go. -5/1/21 at 4:32 p.m., continues with constant anxiety and asking for permission to do anything-she was afraid of getting in trouble. The resident's roommate became agitated because the resident kept going in and out of the room which upset the resident even more. -5/2/21 at 6:38 p.m., the resident was very anxious and was frequently and nervously pacing in the hallway.			

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Psychiatry progress notes indicated the following:
-4/15/21-Resident 54 was seen for staff concerns about mood and behaviors. Staff report the resident is constantly asking where to go, what to do, and permission to do things as she's afraid she will get in trouble. Her presenting symptoms are anxiety, confusion, and wandering. The plan was to obtain some baseline blood work and for staff to provide supportive care and appropriate behavioral interventions.
-4/22/21-resident was seen for recheck of mood and behavior. Staff report she remains anxious and often asks where to go or what to do and had difficulty sitting through meals.
-4/29/21-resident was seen for recheck of mood and behavior. Staff report continued ongoing anxious behavior. She was observed to interact with a nurse about a dried stain on her shirt. The resident was worried about it and had kept asking if it was ok and apologizing. The nurse reassured her it was fine and not to worry but the resident continued to focus on the stain. The plan was to start a medication for anxiety, provide supportive care and appropriate behavioral interventions.

There were no updates made to the care plan or behavioral plan put into place to assist the resident with her ongoing anxiety.

5. On 5/3/21 at 11:00 A.M., the record for Resident 81 was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), Crohns disease, dementia without behavioral disturbance, delusional disorder, anxiety disorder, major depressive disorder, and PTSD (post traumatic stress disorder).

An admission MDS assessment, dated 12/28/20,

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indicated the resident had a BIMS (Brief Interview Mental Status) score of 12 which signified he had moderately impaired cognition. He had multiple mood indicators and verbal behaviors towards others during the assessment.

The resident was observed the following days/times:
-5/2/21 from 12:00 p.m. through 12:23 p.m., Resident 81 was observed to leave the dining room table 5 times to go and toilet himself. He propelled himself to his room by wheelchair (w/c). He appeared unkept with greasy hair and stubble on his face. He appeared uncomfortable and distressed. He was frowning, occasionally would rub his stomach and pursed his lips and let out long breaths. When questioned, he indicated his stomach hurt and he had to keep going to the bathroom. A portable oxygen concentrator was attached to the back of his w/c but there was no oxygen tubing attached to the unit. No staff were observed to assist him or ask if he needed assistance.
-5/3/21 at 10:05 a.m., the resident was propelling himself in his w/c. He appeared unkept and unshaven. He wore a nasal cannula which was attached to his oxygen and was turned on. He appeared very anxious and distressed and indicated he still hadn't felt well. He indicated he wanted to leave and kept going to the exit door of the unit.
-5/5/21 at 12:10 p.m., the resident was observed propelling himself in his w/c, going in and out of the dining room. His oxygen tubing was off and was dragging behind him on the floor. Another resident was observed to pick up the tubing and place it on his w/c. He appeared anxious, distressed, and unable to sit still to eat.

Care plans indicated Resident 81 was at risk for

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mood issues due to depression, dementia and anxiety, had impaired cognition, behavior problems related to verbal behaviors and dementia, an anxiety disorder, depression, and insomnia. The care plan did not indicate the resident had PTSD. Interventions were non-specific and included, but were not limited to, administer psychotropic medications and observe effectiveness, behavioral consults as needed, approach and speak with resident in a calm manner, provide a program of activities that accommodates abilities, provide visible clocks and calendar, and provide a calm environment.

On 5/6/21 at 11:01 A.M., the Director of Social Services was interviewed. During the interview, she indicated the RSD-Resident Services Director was responsible for writing behavior care plans for residents who resided on the secured memory care unit. She indicated residents with behaviors should have monitoring plans in place with person centered interventions.

On 5/6/21 at 2:15 P.M., the DON (Director of Nursing) provided a current copy of the facility policies titled "Secured Locked Unit" and "Behavior Management General" which stated the following: The secured or locked unit is a unit that is separated from other units...used for those residents with limited cognitive or reasoning abilities who lack capacity for re-direction or re-learning including those with late-stage Alzheimer's or other related dementias...Ongoing Review of Need and Care Planning-The care plan goals and interventions should reflect the need to correct or compensate for behavioral concerns including safety of self and others...The Unit...Activities designed for cognitively impaired to decrease boredom and provide an outlet for expression...It is the policy of this

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	facility to identify and safely manage residents who are exhibiting behaviors related to psychiatric diagnoses or who may present a danger to themselves or others, Resident will be provided with a resident centered behavior management plan...Complete a Care Plan-update with changes and/or new behaviors, Involve social service and activities department...include resident specific interventions...." 3.1-37(a)			
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,			

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	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 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.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review and interview the facility failed to quarantine a resident by placing them in TBP (Transmission Based Precautions) upon admission for 1 of 2 resident's admitted to the facility from the hospital. (Resident 58) Finding Includes: During an observation, on 5/2/21 at 11:59 A.M., Resident 58 was observed outside smoking with other residents. During an observation, on 5/3/21, at 10:40 A.M., Resident 58 was seen in the hallway outside the chapel. During an observation on 5/3/21 at 2:20 P.M., Resident 58's room did not have appropriate TBP (Transmission Based Precautions), to indicate she was in isolation and what PPE (Personal Protective Equipment) to wear outside or room or on her door. A record review was conducted, on 5/4/21 at 2:30 P.M., for Resident 58 and indicated she was discharged return not anticipated, on 4/8/21 to her home, and re-admitted to the facility, on 4/23/21, from the hospital. Her diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, hyperlipidemia, cerebral infarction anemia, cellulitis of left lower limb, hypomagnesemia, cognitive communication deficit, severe protein-calorie calorie malnutrition and chronic pain.	F 0880	**F 880** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #58 was placed in transmission based precautions to complete the required isolation for an unvaccinated new admission. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: The DON or Designee completed audit of all new unvaccinated admissions for the past 14 days to ensure quarantine by placing them in TBP (Transmission Based Precautions) The DON or designee will complete the following: Ensure the resident/residents affected/potential affected has been isolated in Transmission Based Precautions according to CDC and IP recommendations and ensure care giving staff are educated on isolation procedures. Ensure all staff are aware of who is on isolation and appropriate signage implemented. Policy: Criteria for Covid 19 isolation	06/06/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	05/07/2021

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	There was no completed MDS (Minimum Data Set) assessment present to review. Immunization records did not indicate Resident 58 had been vaccinated for COVID-19. A care plan, revised 4/23/21, indicated Resident 58 was at risk for COVID-19 related to potential exposure with recent hospitalization/admission from community. The interventions, dated 5/2/21, indicated to determine appropriate barriers to apply based on isolation precaution category and activities to be performed e.g., masks, gowns, gloves and to implement droplet isolation precautions. A care plan, dated 4/23/21, revised 5/4/21, indicating Resident 58 was on droplet precautions related to COVID-19 pandemic. An intervention, dated 4/23/21, indicated to implement droplet isolation precautions. During an interview, on 5/4/21 at 2:10 P.M., the DON indicated Resident 58 had not been in isolation since her 4/23/21 admission and should have been in isolation when she was admitted to the facility and indicated the resident had refused the COVID-19 vaccine. During an observation, on 5/5/21 at 12:43 P.M., Resident was observed out in the hallway walking toward the nurses station with her personal belongings in her wheelchair telling staff she was going home. During an observation, on 5/6/21, Resident 58 was observed walking down the hallway and went outside to smoke, no intervening from staff		**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** A Root Cause Analysis (RCA) was conducted with the Infection Preventionist (IP) and input from the IDT and the facility Medical Director/IP/DON. The root cause was identified resulting in the facility's failure. Solutions were developed and systemic changes were identified that need to be taken to address the root cause. The Infection Preventionist and IDT reviewed the LTC infection control self-assessment and identified changes to make accurate **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** After the IDT and Infection Preventionist completed the RCA and LTC infection control assessment, training identified above was implemented to facility staff. The training will be conducted by the DON, IP or Medical Director with documentation of completion. To ensure Infection Control Practices are maintained, the following monitoring will be implemented.	

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	observed. No documentation present in progress notes from 4/23/21 to 5/5/21 to indicate Resident 58 had not maintained isolation precautions and interventions provided by the facility. A policy was provided by the DON, on 5/7/21 at 2:49 P.M., titled, "Visitors and Isolation Precautions", revised 11/30/2017, and indicated the policy was the one currently being used by the facility. The policy indicated "...The proper isolation sign placed near the door opening that describes the type of isolation and the proper procedures with PPEs to wear when entering the room to reduce the spread of infectious pathogens...." 3.1-18(b)(2)			