STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 00 B. WING	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOOVERWOOD	7001 HOOVER RD INDIANAPOLIS, IN 46260

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Nursing Home Complaints IN00420378, IN00425592 and IN00428227. Complaint IN00420378 - No deficiencies related to the allegations are cited. Complaint IN00425592 - Federal/State deficiencies related to the allegations are cited at F676, F677, F679 and F684. Complaint IN00428227 - No deficiencies related to the allegations are cited. Survey dates: February 27, 28, 29 and March 1, 4, 5 and 6, 2024. Facility number: 000001 Provider number: 155001 AIM number: 100275310 Census Bed Type: SNF: 148 Residential: 19 Total: 167 Census Payor Type: Medicare:14 Medicaid: 94 Other: 40 Total: 148 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	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 the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 4/1/2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Voss	Administrator	03/28/2024

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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	Quality review was completed on March 14, 2024.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and record review, the facility failed to ensure a resident had a self-medication administration assessment and to ensure medications were not left unattended in a resident's room for 1 of 3 residents reviewed for medication administration. (Resident 99) Finding includes: During an observation, on 2/28/24 at 10:00 a.m., Resident 99 had a box of Refresh Tears Ophthalmic Solution eye drops (for dry eyes) and 16 pills spread out on his bedside table. The resident indicated he was missing 2 pills. During an observation, on 2/28/24 at 10:09 a.m., RN 14 entered the resident's room. Resident 99 informed the nurse he was missing two pills. The nurse indicated the pills were there and the resident asked the nurse to show him the pills. RN 14 could not show him the two pills and left the room leaving the pills and eye drops on the bedside table. During an observation, on 2/28/24 at 10:12 a.m., RN 14 entered the resident's room carrying a medication cup. The nurse informed the resident she had his metformin (a blood pressure medication) and did not have his torsemide (a diuretic medication used to treat edema). The nurse indicated she would have to take it out of	F 0554	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident 99 Medications have been reviewed. Resident 99 will not self administer his medications. Medications will not be left unattended in resident's room. **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;** -No other residents have been affected. Any resident that is deemed by the Interdisciplinary Care team (IDT) and receives a Physician's Order to use and keep medications at bedside, have the potential to be affected. -Inservice to be completed by 4/1/2024 educating Nursing staff on Medication Administration-Self Administration Evaluation. **What measures will be put into place and what systemic**	04/01/2024

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	the emergency drug kit (EDK). The clinical record for Resident 99 was reviewed on 3/1/23 at 3:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus (DM), congestive heart failure, and right AKA (above the knee amputation). A review of the physician's orders for Resident 99 included: a. magnesium oxide (a dietary supplement) 400 mg (milligram) tablet, give 1 tablet by mouth two times a day. b. aspirin 81 mg chewable tablet, give 1 tablet by mouth every dayshift. c. folic acid (a dietary supplement) 1 mg tablet, give 1 tablet by mouth one time a day. d. ferrous sulfate (for anemia) tablet 325 mg, give 1 tablet by mouth three times a day for anemia. e. potassium chloride extended release (a supplement) 20 milliequivalent (MEQ) tablet, give 1 tablet by mouth one time a day. f. refresh tears ophthalmic solution (for dry eyes), instill 1 drop in both eyes four times a day. g. vitamin A (a dietary supplement) 3 mg tablet, give 1 tablet by mouth two times a day. h. vitamin C (a dietary supplement) 250 mg, give 1 tablet by mouth two times a day. i. zinc sulfate (a dietary supplement) 220 mg, give 1 tablet by mouth two times. j. vitamin D (a dietary supplement) 50 micrograms (mcg), give 1 tablet by mouth one time a day. k. a multivitamin tablet, give 1 tablet by mouth one time a day. l. Tylenol extra strength 500 mg, give 1 tablet by mouth three times a day. m. clopidogrel bisulfate (a blood thinner) 75 mg, tablet give 1 tablet by mouth in the morning. n. senna-docusate sodium 8.6-50 mg tablet, give 1 tablet by mouth every 12 hours as needed a		**changes will be made to ensure that the deficient practice does not reoccur;** - Inservice to be completed by 4/1/2024 educating Nursing staff on Medication Administration-Self Administration Evaluation. -DNS/designee will do daily (Monday through Friday) rounds to ensure medications are not left at the bedside of residents **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; and by what date the systemic changes for each deficiency will be completed** - The DNS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 3 months, with results reported to the Quality Assurance and Performance Improvement Committee.	

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	maximum of 2 tablets. o. metformin HCL (for diabetes mellitus) 500 mg tablet, give 2 tablets by mouth two times a day. p. torsemide (a diuretic) 40 mg tablet, give 2 tablets by mouth one time a day. q. glipizide (for diabetes mellitus) 5 mg tablet, give 2 tablets by mouth two times a day. A self-medication assessment was not found during the record review or provided by the facility upon exit. During an interview, on 2/28/24 at 10:06 a.m., the resident indicated he always poured his pills out on the bedside table to make sure he received the right ones. There had been several times he was missing pills. The resident was missing one of his diabetes pills and one of his diuretic pills. The resident indicated this was not the first time he was missing pills. During an interview, on 2/28/24 at 10:10 a.m., RN 14 indicated she did not leave the pills with the resident. The nurse had to get the resident some water to take his medication. The pills on the bedside table were his morning medication. RN 14 did not know why his box of eye drops were left on the table and the pills should not be left with the resident. During an interview, on 2/28/24 at 10:14 a.m., Unit Manager (2A UM) indicated the pills were not supposed to be left alone in the resident's rooms. The resident did not have a self-medication administration assessment and no order to keep medications at bedside. The medication should not be left in the room. During an interview, on 3/1/24 at 9:25 a.m., RN 12 indicated residents should not have medication			

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	left in the room unless a self-medication assessment was completed. During an interview, on 3/5/24 at 4:32 p.m., the Administrator indicated the resident did not have a self-medication assessment and he did not give his own medication. During an interview, on 3/13/23 at 3:55 p.m., the Director of Nursing (DON) indicated the nurses should never leave medication in a resident's room unattended. A current facility policy, titled "Medication Administration-Self Administration Evaluation," dated as revised 9/2019 and received by the DON on 3/5/24 at 10:35 p.m., indicated "...Medication administration shall utilize the following guidelines: If the resident wishes to administer their own medications, they will be assessed by the nursing staff as to their capability. The Interdisciplinary team (IDT) and physician will review the assessment and decide if the resident will be allowed to administer their medication. If it is the decision to not allow the resident to administer their medications, then all medication shall be removed from the resident's room and kept in the nursing station. An evaluation when the resident requests to self-medicate, upon a change of condition and every 6 months...." A current facility policy, titled "Medication Administration," dated as revised 8/2022 and received by the Assistant Director of Nursing (ADON) on 3/1/24 at 11:30 p.m., indicated "...To assure that medication and treatments are administered safely and correctly...All medications and treatments shall be ordered by the physician and given by a licensed nurse or qualified medication aide (QMA)...Remain with the resident			

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	while they are taking medications. Do not leave medications in the resident room...." 3.1-11(a)			
F 0642 SS=D Bldg. 00	483.20(h)-(j) Coordination/Certification of Assessment §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. Based on interview and record review, the facility failed to ensure a resident with a PASARR	F 0642	**What corrective action(s) will be accomplished for those**	04/01/2024

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	(Preadmission Screening and Resident Review) level II was recorded on the Minimum Data Set (MDS) assessment for 2 of 3 residents reviewed for PASARR Minimum Data Set assessments. (Resident 105 and 58) Findings include: 1. The clinical record for Resident 105 was reviewed on 3/6/24 at 2:26 p.m. The diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, and generalized anxiety disorder. A notice of PASARR Level II outcome, dated 1/3/22, indicated the determination was long term approval without specialized services. A notice of PASARR Level II outcome, dated 11/2/23, indicated the resident review was because of a change in mental health medications. The determination was long term approval without specialized services. An MDS assessment, dated 9/13/23, indicated the resident did not have a PASARR level II.2. The clinical record for Resident 58 was reviewed on 2/29/24 at 9:40 a.m. The diagnoses included, but were not limited to, schizoaffective disorder bipolar type, schizophrenia, major depressive disorder single episode, and dementia. A notice of PASARR Level II outcome, dated 4/6/2020, indicated Resident 58 was approved without specialized services. The resident met the criteria for PASARR determination with the diagnoses of schizoaffective disorder, depressive type, schizophrenia, dementia, and bipolar disorder.		**residents found to have been affected by the deficient practice;** -Resident 58's medical record has been reviewed for a PASARR (Preadmission Screening and Resident Review) Level II and the Minimum Data Set (MDS) has been updated. -Resident 105's medical record has been reviewed for a PASARR (Preadmission Screening and Resident Review) Level II and the Minimum Data Set (MDS) has been updated. **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;** -Any resident that has a mental disorder, intellectual disability or a related condition has the potential to be affected. -Inservice to be completed by 4/1/2024 educating staff on the PASARR/Level II program **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Inservice to be completed by 4/1/2024 educating staff on the PASARR/Level II program -MDS/designee will Review all resident's that have a mental	

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	A MDS assessment, with a target date of 4/3/23, indicated the resident was not currently considered by the state level II PASRR process to have a serious mental illness and/or an intellectual disability or a related condition. During an interview, on 3/6/24 at 10:34 a.m., the SSD (Social Services Director) indicated the annual MDS assessment in 2023 should have been marked as the resident had a current level II PASARR determination. A current policy, titled "PASARR Program," dated as revised in November 2018 and received from the Director of Nursing on 3/6/24 at 5:05 p.m., indicated "...The facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the integrated setting appropriate to their needs...." 3.1-31(d)		disorder, intellectual disability or a related condition to ensure their MDS is coded accurately -Social Services/designee will complete the PASARR question on the MDS **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; and by what date the systemic changes for each deficiency will be completed** **-** The MDS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 3 months, with results reported to the Quality Assurance and Performance Improvement Committee.	
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:			

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	§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on observation, interview and record review, the facility failed to develop and implement resident specific interventions to address the identified limitations in the ability to effectively communicate requests and needs, to listen to others, and to participate in social conversation for 1 of 3 residents reviewed for activities of daily living (ADL) care related to communication. (Resident K) Finding includes: During an observation, on 2/27/24 at 4:05 p.m.,	F 0676	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Unable to identify Resident K **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;**	04/01/2024

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	Resident K walked up to Certified Nursing Aide (CNA) 5 and spoke in another language. CNA 5 laughed at the resident and did not try to find out what the resident wanted. The resident walked away. CNA 5 indicated the resident spoke Russian. The CNA did not try to use any type of translation service. During an observation, on 3/4/24 at 3:51 p.m., Resident K was sitting up in the common area with other residents. The television was on and in English. A staff member had offered water to the other residents but did not offer Resident K any water. During an interview and observation, on 3/4/24 at 3:58 p.m., Qualified Medication Aide (QMA) 6 was asked about the staff not offering Resident K any water. QMA 6 indicated she could usually figure out if the resident wanted water by trying to hand it to the resident. QMA 6 handed the resident a cup of water, the resident accepted the cup, took a few sips, and handed the cup back. QMA 6 indicated she thought the water might be too cold, so she added some warm water. The resident had continued to speak in Russian. The resident handed the water back. QMA 6 then indicated she thought the resident wanted something sweet to drink although she did not offer the resident a sweet drink. The staff did not try to use any type of translation service to figure out what the resident wanted to drink. The clinical record for Resident K was reviewed on 3/5/24 at 9:59 a.m. The diagnoses included, but were not limited to, anemia in chronic kidney		- All residents have the potential to be affected by the alleged deficient practice -Inservices to be completed by 4/1/2024 educating staff on Resident Rights ensuring residents are able to effectively communicate requests and needs, to listen to other and to participate in social conversations. -Residents that speak a foreign language will be reflected on the assignment sheet **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Inservices to be completed by 4/1/2024 educating staff on Resident Rights ensuring residents are able to effectively communicate requests and needs, to listen to others and to participate in social conversations - Facility will implement daily rounds provided each business day by Management, ensuring residents are able to effectively communicate requests and needs, to listen to others and to participate in social conversations - Facility to provide on going training on translation services, as needed **How the corrective action(s) will be monitored to ensure the**	

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	disease, unspecified dementia, depression, a cognitive communication deficit, and anxiety disorder. A care plan, dated 12/31/22, indicated the resident's life story included the resident only spoke Russian. The interventions included, to encourage the resident to share her life story with staff for person centered care. A care plan, dated 6/10/22 and last revised on 2/27/24, indicated the resident's primary language was Russian. The resident's speech was clear when speaking with a Russian translator and could be understood without difficulty. The interventions included anticipating and meeting needs, promoting proper communication with others, utilizing family, and using Luna (a language translation agency) to help with translation. A care plan, dated 6/10/22 and last revised on 11/10/23, indicated the resident presented with severely impaired cognitive function related to the diagnosis of dementia. The interventions included, but were not limited to, asking yes/no questions to determine needs, utilize the family, and use Luna as needed for assistance with translation. A care plan, dated 6/10/22 and last revised on 6/14/23, indicated the resident's strengths included, she could ambulate on her own with a walker, could feed herself, and could appropriately converse with translators and family members in Russian. The resident care guide, not dated, indicated the resident was a fall risk and to remind her to always use her walker and to cue for activities of daily		**deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** - The DNS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 3 months, with results reported to the Quality Assurance and Performance Improvement Committee.	

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	living. The resident needed extensive assistance with bathing and dressing. The care guide did not include information on the resident's language. During an interview, on 3/1/24 at 1:44 p.m., the Speech Therapist (ST) 10 indicated she was fluent in Spanish but not Russian. ST 10 indicated it was ideal for the family to translate for the resident and when the family could not then the facility would use Google translate. The family needed to take the initiative and make a board with certain phrases or words. During an interview, on 3/4/24 at 4:07 p.m., the memory care Social Services Director (SSD) indicated the resident's family was utilized to translate for the resident. The staff would call the resident's son which was more successful than using the language service called Luna. The Luna translator on the phone did not understand the resident. The family would visit often. The facility had a Russian communication board where the resident could point to things, but the SSD was not sure if it was ever utilized for the resident. The staff were trained to use Luna as the translation provider and the number to Luna was at the nurses' desk. The staff had also been taught to utilize the resident's family and would call them if the resident was upset or tearful. During an environmental tour with the Director of Maintenance, the Administrator, the Chief Community Operations Officer, and the Director of Nursing, on 3/5/24 at 12:05 p.m., the following was observed: Resident K was sitting in the common area close to her room. Staff were attempting to get permission from the resident to tour her room by			

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	asking in English and pointing to her room. The Director of Maintenance indicated the resident spoke Russian and would not understand the staff was asking for permission to enter the resident's room. The staff on the tour started to walk into the resident's room. The facility staff had to be asked again how to confirm the resident was giving permission to walk into her room. The Chief Community Operation Officer indicated he could use his phone to translate. The resident looked at the phone and nodded her head. A current policy, titled "Resident Rights," dated as revised on 10/2018 and received from the Administrator upon entrance to the facility, indicated "...The facility shall use Resident Rights [as identified by the Federal and State Guidelines] as the basis for their services to the residents in providing care that meets the needs and rights of the residents...Employees shall be provided education of Resident's Rights in orientation, annually thereafter and on a prn basis...You have the right to a dignified existence, self-determination, and communication with and access to the persons and services inside and outside the facility...You have the right to be informed, and participate in, your treatment. This includes the right to...Be fully informed in language that you can understand...You have the right to be treated with respect and dignity, including...The right to reside and receive services in the facility with reasonable accommodation of your needs and preferences except when to do so would endanger the health or safety of you or other residents...." This citation relates to Complaint IN00425592. 3.1-38(a)(2)(E)			

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to develop and implement resident specific interventions to ensure a cognitively impaired resident with a past history of elderly abuse received the necessary services to meet her grooming, bathing, and clothing needs for 1 of 2 residents reviewed for activities of daily living (ADL) care. (Resident T) Finding includes: During an interview, on 3/5/24 at 5:16 p.m., the Social Services Director indicated Resident T was considered an elder abuse patient and was very private with showering. The resident would clean herself up at the sink. During an observation, on 2/27/24 at 1:38 p.m., Resident T had facial hair above her top lip which looked like a mustache. Her longer than shoulder length hair was not combed and was oily and dirty. She had on a gray zip up sweatshirt and gray pants with a white stripe down the side. During an observation, on 2/29/24 at 11:40 a.m., the resident was sitting up in a regular chair in the common area. She had on a gray zip up sweatshirt and gray pants with a right stripe going down the side of them. The resident's hair was still oily. During an observation, on 3/1/24 at 11:16 a.m., the resident was sitting up in a chair in the common area, her hair was not combed and was dirty. She	F 0677	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Unable to identify Resident T **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;** - All residents have the potential to be affected by the alleged deficient practice -Inservices to be completed by 4/1/2024 educating staff on Activities of daily living (ADL's) related to grooming, bathing and clothing needs. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - - Inservices to be completed by 4/1/2024 educating staff on Activities of daily living (ADL's) related to grooming, bathing and clothing needs.	04/01/2024

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	was wearing a gray zip up sweatshirt and gray pants with a white stripe down the side of them. The resident still had facial hair above her lip which looked like a mustache. During an observation, on 3/4/24 at 4:29 p.m., the resident was sitting up in a chair in the common area. Her hair was not brushed and was dirty. She was still wearing the same gray zip up sweatshirt and gray pants with the white stripe down the side. She still had facial hair above her upper lip which looked like a mustache. During an observation, on 3/5/24 at 11:16 a.m., the resident was still wearing gray pants with the white stripe down the side and the gray zip up sweatshirt. The resident's hair was still dirty. The clinical record for Resident T was reviewed on 3/5/24 at 3:35 p.m. The diagnoses included, but were not limited to, unspecified dementia with agitation and repeated falls. A care plan, dated 3/27/23, indicated the resident had an ADL self-performance deficit related to dementia. The interventions included, but were not limited to, the resident required extensive assistance with bathing and showering and required staff assistance with dressing. The care plan did not include the resident would bathe herself in the sink or having a history of elder abuse. The care plan did not document any new interventions or alternate ways to assist the resident with bathing, showering, or dressing since 3/27/23. A care plan, dated 4/3/23 and last revised on		- Facility will implement daily rounds provided each business day by Management, to ensure residents are groomed, bathed and dressed appropriately. - Facility to provide on going training and skills validations for ADLs, as needed **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; and by what date the systemic changes for each deficiency will be completed** **-** The DNS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 3 months, with results reported to the Quality Assurance and Performance Improvement Committee.	

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	2/27/24, indicated the resident had moments of refusing showers and ADL care. The resident would not let the staff shave her face and would refuse to change clothes for several days. The goal was for the resident to cooperate with care. The interventions included, but were not limited to, administering anti-anxiety medication prior to showers, allowing the resident to make choices about her treatment, and to provide a sense of control. The care plan did not include the resident would bathe herself in the sink or having a history of elder abuse. The care plan did not document any new interventions or alternate ways to clean the resident's hair or address the refusals of showers since 12/12/23. The "Task" section of the Electronic Health Record (EHR) indicated the resident refused showers on 2/12/24, 2/15/24, 2/19/24 and 2/22/24. The "Task" section did not include if an alternative type of bathing was completed or if a different staff tried to assist the resident with care. During an interview, on 3/5/24 at 4:20 p.m., the Assistant Director of Nursing Services (ADNS) indicated the resident had refusals of care. The resident refused her shower on February 29th and the documentation did not include if another type of bathing was completed. During an interview, on 3/5/24 at 5:16 p.m., the Social Services Director indicated the resident's care plan did not include the resident would clean herself up at the sink, was considered an elder abuse patient, and was very private with			

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	showering. The facility had not considered alternate methods to cleanse the resident's hair other than showering. A current policy, titled "Activities of Daily Living," dated as revised on 1/2023 and received from the Director of Nursing Services (DNS) on 3/6/24 at 5:05 p.m., indicated "...Residents will receive assistance with activities of daily living based on their needs, keeping in mind that safety is always a consideration...The ability of the resident to perform activities of daily living is determined by an assessment of the resident. Based on that assessment, the amount of assistance the resident requires is planned...independent, stand-by assist, one assist or two assist ...Those activities include, but are not limited to...Personal hygiene...Dressing...." This citation relates to Complaint IN00425592. 3.1-38(a)(2)(A) 3.1-38(a)(3)(B) 3.1-38(a)(3)(D)			
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview and record	F 0679	**What corrective action(s) will**	04/01/2024

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	review, the facility failed to ensure there was an ongoing program of cognitively stimulating activities for residents diagnosed with dementia for 4 of 9 residents reviewed for activities. (Resident I, F, U and V) Findings include: 1. During an observation, on 2/27/24 at 2:44 p.m., Resident I was wandering in the hallway. During an observation, on 2/28/24 at 11:23 a.m., Resident I was wandering in the hallway. During an observation, on 2/28/24 at 3:44 p.m., the resident was sitting in a recliner in the hallway, music was playing in the room next to the hallway and the resident was rocking her body back and forth. During an observation, on 2/29/24 at 12:06 p.m., the resident was sitting up in a chair in the dining room and waiting for her food and drink. During an observation, on 3/1/24 at 11:18 a.m., the resident was sitting up in the common area with a female staff and other residents. The staff was hitting a purple balloon back and forth at the residents. During an observation, on 3/4/24 at 4:03 p.m., the resident was sitting up in a chair in the common area close to the nurse's station. No other residents or staff were present in the area. During an observation, on 3/5/24, the resident was in room 118 which was a different resident's room, and the staff was trying to redirect her out of the room.		**be accomplished for those residents found to have been affected by the deficient practice;** - Unable to identify Resident's I, F, U, and V **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;** - All residents have the potential to be affected by the alleged deficient practice -Inservices to be completed by 4/1/2024 educating staff that there is ongoing programing of cognitively stimulating activities for residents diagnosed with dementia -Activities Director/designee will audit the activities participation log. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - - Inservices to be completed by 4/1/2024 educating staff that there is ongoing programing of cognitively stimulating activities for residents diagnosed with dementia. - Facility will implement daily rounds provided each business day by Management, to ensure residents are engaged in	

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	During an observation, on 3/5/24 at 11:35 a.m., the resident continued to wander in the hallway while other residents were in the common area with the activity staff. During an observation, on 3/6/24 at 11:14 a.m., the resident was wandering in the hallway. The clinical record for Resident I was reviewed on 3/5/24 at 4:45 p.m. The diagnoses included, but were not limited to, unspecified dementia with other behavioral disturbance, delusional disorder, chronic pain, adult failure to thrive, insomnia, and the need for assistance with personal care. A physician's order, dated 11/10/23, indicated the resident had a wander guard placed for safety. A care plan, dated 8/21/21 and last revised on 11/20/23, indicated the resident was at risk for elopement related to attempts to get off the unit. The interventions included, but were not limited to, distracting from wandering by offering pleasant diversions, the resident was best redirected with 1:1 staff, she enjoyed reading books, listening to music, and going on walks. A care plan, dated 1/27/22 and last revised on 7/3/23, indicated the resident enjoyed being out in nature, listening to country music, reading, and bird watching. A care plan, dated 11/21/22 and last revised on 12/26/22, indicated the resident had to be reminded of the location and the time of activities. The resident enjoyed being around peers with similar interests. The goal was for the resident to participate in activity groups daily with encouragement and directions from staff. The interventions included, but were not limited to,		activities programs that are appropriate to the abilities and interests of the resident. --Activities Director/designee will audit the activities participation log. **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; and by what date the systemic changes for each deficiency will be completed** - The Activities Director/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 3 months, with results reported to the Quality Assurance and Performance Improvement Committee.	

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	five short and simple instructions, demonstrate task, inform of the times of activities, walk to and from Bible study and other groups and put the resident in groups with peers she could socialize with. The activity logs for Resident I were reviewed and indicated the following: a. December 2023, there were 11 days no activities were marked as completed for the entire day. b. January 2024, there were 10 days no activities were marked as completed for the entire day. c. February 2024, there were 7 days no activities were marked as completed for the entire day. 2. During an observation, on 2/28/24 at 3:48 p.m., Resident F was propelling herself in the wheelchair. The only activity occurring on the memory care unit was the television was on. During an observation, on 2/29/23 at 11:44 a.m., Resident F was sitting up in her wheelchair in the common area. There was one female staff present and she was looking at her cellular phone. The television was on in the common area. During an observation, on 3/1/24 at 11:12 a.m., the resident was sitting up in her wheelchair in the common area. She had her eyes closed and her left hand was resting against the side of her face. The staff was trying to wake up the resident so she would look at the purple balloon the staff was holding. The resident continued to keep her eyes closed. During an observation, on 3/4/24 at 3:48 p.m., the resident was sitting up in the common area. The television was on, and CNA 27 was in the room. During an observation, on 3/5/24 at 11:14 a.m., the			

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	resident was sitting up in the common area with other residents in the room. The resident had her head tilted down and the staff was not interacting with her. There was music playing which had no words to it. The female staff in the room was singing words to the song to a different female resident in the room. The staff was not engaging residents other than the one she was singing to. The clinical record for Resident F was reviewed on 3/1/24 at 3:04 p.m. The diagnoses included, but were not limited to, unspecified dementia with unspecified severity, generalized muscle weakness, insomnia, anxiety, and depressive episodes. A care plan, dated 2/10/21 and last reviewed on 1/22/24, indicated the resident enjoyed listening to music, socializing with other residents, and participating in daily activities only when she was up to it. The goal was for the resident to attend 3-4 group activities on the unit per week. The interventions included, but were not limited to, asking the resident if she wanted to come to activities, reminding the resident what time the activities start, and taking the resident to and from the activities. The activity logs for Resident F were reviewed and indicated the following: a. December 2023, there were 11 days which had no activities checked as completed for the entire day. b. January 2024, there were 10 days which had no activities checked as completed for the entire day. c. February 2024, there were 9 days which had no activities checked as completed for the entire day. 3. During an observation, on 2/27/24 at 2:56 p.m., Resident U was sitting up in her wheelchair in the			

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	hallway outside of her room. There were other residents in the activity area at the end of the hall with one activity staff and one CNA working on a word search on the white eraser board. The resident had her head tilted down towards her chest. During an observation, on 2/28/24 at 11:07 a.m., Resident U was sitting up in her wheelchair in the common area, her chin was tilted down towards her chest, and her eyes were closed. There were no staff present in the common area. During an observation, on 2/29/24 at 12:05 p.m., the resident was sitting up in her wheelchair in the dining room. During an observation, on 3/1/24 at 11:10 a.m., the resident was sitting up in the wheelchair in the common area. There was one staff present in the room. No activity was occurring and then the staff picked up the newspaper and started reading it to the residents in the room. During an observation, on 3/4/24 at 3:45 p.m., the resident was sitting up in the common area at the end of the hall. The television was on and there was one female staff in the room. The staff was not providing an activity or engaging with the residents. During an observation, on 3/6/24 at 11:25 a.m., the resident was sitting up in her wheelchair in the hallway outside of her room. Her eyes were closed, and her head was tilted towards her chest. The clinical record for Resident U was reviewed on 3/1/24 at 9:42 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, urinary tract infection, abnormal weight loss, and major			

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	depressive disorder. A care plan, dated 8/16/23, indicated the resident had a diagnosis of insomnia. The interventions included, but were not limited to, encouraging the resident to remain active in the evening hours to help sleep at night and limit naps to the early part of the day. A care plan, dated 8/8/23, indicated the resident loved to travel. The interventions included encouraging the resident to be active in activities, invite to activities of interest, and to provide with a monthly activity calendar. The activity logs for Resident U were reviewed and indicated the following: a. December 2023, there were 10 days which had no activities marked as completed for the entire day. b. January 2024, there were 10 days which had no activities marked as completed for the entire day. c. February 2024, there were 5 days which had no activities marked as completed for the entire day. 4. During an observation, on 2/27/24 at 2:02 p.m., Resident V was slumped to the left side in her Broda chair (chair used for positioning). CNA 5 was also in the common area. The television was on, and the resident was not positioned towards the television. During an observation, on 2/28/24 at 3:45 p.m., Resident V was sitting up in her Broda chair, the television was on, and one staff was present in the room. There was no activity other than the television. During an observation, on 3/1/24 at 11:22 a.m., the resident was sitting up in a high back wheelchair			

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	at a table in the common area at the end of the hallway. There were no staff in the common area and the television was turned on. During an observation, on 3/5/24 at 11:10 a.m., the resident was sitting up in a high back wheelchair in the common area at the end of the hall. There was no staff present and the television was on. During an observation, on 3/6/24 at 11:27 a.m., the resident was sitting up in the high back wheelchair in the common area at the end of the hall. CNA 5 was in the common area and the television was on. There were no other activities. The clinical record for Resident V was reviewed on 3/1/24 at 3:38 p.m. The diagnoses included, but were not limited to, fracture of the left femur (the thigh bone), major depressive disorder, and unspecified dementia. A care plan, dated 1/22/23, indicated the resident loved country music, basketball, coloring, and drawing. The interventions included, but were not limited to, encourage the resident to participate in group activities, remind the resident of musical events, provide with coloring materials, invite to activities of interest, and provide a monthly activity calendar. The activity logs for Resident V were reviewed and indicated the following: a. December 2023, there were 9 days which had no activities marked as completed for the entire day. b. January 2024, there were 8 days which had no activities marked as completed for the entire day. c. February 2024, there were 7 days which had no activities marked as completed for the entire day. During an interview, on 3/6/24 at 2:08 p.m., the			

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	Activity Director indicated there would be one activity staff scheduled for each unit. The staff would alternate working on weekends. On the dementia unit, the activity staff offered regular programming in the morning and again in the afternoon after lunch. The Certified Nursing Aides (CNAs) were to engage with the residents for activities. The CNAs were taught to do table ball, reminiscing activities, offer nail care, and help in exercise. Music was another activity along with activities familiar to residents. They have had some residents fold hand towels and have baby dolls for other residents. The Activity Director did not have a regular schedule to check the activities in the memory care unit. Since there were 42 residents on the memory care unit, the CNAs were supposed to engage the residents who were not in the activity group. The CNAs had been provided education and materials. During an interview, on 3/6/24 at 11:25 a.m., Activity staff 28 indicated she covered the memory care unit with 42 residents. Resident I would usually not stay for the group activities, and she liked to rearrange the closet and to walk. Resident U would attend morning activities and had been sleeping a lot the last couple of weeks and would not stay awake for activities. Resident V stayed on the other side of the hall and would only do sensory activities. Activity staff 28 was by herself and could not get everyone to the activities by herself. The CNAs were supposed to provide activities for Resident V. Resident F had declined and would sleep a lot. A current facility policy, titled "Activity Program," dated as revised on 1/2023 and received from the Director of Nursing Services on 3/6/24 at 5:05 p.m., indicated "...The facility will provide an activities program appropriate to the abilities and interests			

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	of the residents being served...Staff will assist residents to participate in social and recreational activities...There are opportunities for family of residents with dementia to be involved in activity program, both planned and unplanned...For residents with dementia, activities will be provided that accomplish the following...Recognize the resident with dementia as a mature adult...Encompass both small groups with similar cognitive levels and one-to-one opportunities...Match the resident's cognitive, sensory and physical capabilities...Promote engagement in a manner that supports the resident's communication ability...Match the resident's past and current interests...Promote creative artistic expression...Meet the resident's spiritual and religious needs...Allow for flexibility based on the resident's sleep and wake pattern...Allow for planned and unplanned participation...The life story of residents with dementia will be documented to create opportunities for engagement that includes major life events, hobbies, interests, favorite foods, cultural and spiritual practices...." This citation relates to Complaint IN00425592. 3.1-33(a) 3.1-33(b)(1) 3.1-33(c)			
F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with			

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	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure services were provided to effectively administer back blows for a choking resident in accordance with treatment guidelines established by the facility and failed to ensure the plan of care was effectively revised with accurate care information (Resident S). This deficient practice resulted in Resident S experiencing a choking episode with a change in the level of consciousness which required emergent treatment. The facility also failed to ensure residents maintained upright positioning while sitting in chairs (Resident V and F), to ensure the physician was notified for blood sugars above specified parameters and to ensure weights were completed daily (Resident 99) for 4 of 4 residents reviewed for quality of care. Findings include: 1. A Facility Reported Incident (FRI) report, dated 1/4/24 at 12:40 p.m., indicated Resident S was in the dining room eating lunch when the nursing staff observed the resident choking on her food and her color was changing. The resident was not able to cough or clear her airway. The Heimlich maneuver and suctioning were performed. Food particles were suctioned from the resident's mouth. The resident's code status was confirmed as do not resuscitate (DNR). The Power of Attorney (POA) was called to notify of the situation and authorization was obtained to call 911 to send the resident out of the facility for care. The resident was not responsive after the Heimlich and suctioning were performed. The Registered Nurse (RN) manager attempted the sternal rub, elevated the resident's arms above her	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident S no longer resides at the facility -Unable to identify Residents V and F -Resident 99's medical record was reviewed to ensure that the Physician is notified of blood sugars above specified parameters and weights are completed daily **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 po;** - All residents have the potential to be affected by the alleged deficient practice. -Education to be provided via inservicing by 4/1/2024, ensuring that back blows are administered if a resident is choking, care plans are updated with accurate care information, residents are positioned appropriately, Physician notification of blood sugars above specified parameters and weights are completed daily, if ordered. **What measures will be put into place and what systemic**	04/01/2024

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	head and leaned the resident forward in her dining chair. The resident was observed not breathing and two staff verified the resident's respirations had ceased and there was no pulse. The Emergency Management Services (EMS) arrived and confirmed the DNR code status and lack of pulse. No other actions were performed. The report did not include documentation to indicate the specific steps performed by staff during the provision of the Heimlich Maneuver. Google-Merriam Webster-indicated the definition of the Heimlich maneuver was "the manual application of sudden upward pressure on the upper abdomen of a choking victim to force a foreign object from the trachea." The website page https://www.redcross.org/content/dam/redcross/atg/PDFs/Take_a_Class/Adult_Ready_Reference_Card.pdf indicated " ...Conscious Choking Cannot cough, speak, or breathe ...Give 5 [five] back blows ...Give 5 abdominal thrusts ...Continue care Give sets of 5 back blows and 5 abdominal thrusts until the object is forced out, the person can cough forcefully or breathe, or the person becomes unconscious ..." The clinical record for Resident S was reviewed on 2/29/24 at 10:56 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and dysphagia (difficulty swallowing). A quarterly Minimum Data Set (MDS) assessment, dated 11/7/2023, indicated the signs and symptoms of a potential swallowing disorder were positive for the resident holding food in her mouth/cheeks or positive for the resident to have residual food in her mouth after meals.		**changes will be made to ensure that the deficient practice does not reoccur;** - Education to be provided via inservicing by 4/1/2024, ensuring that back blows are administered if a resident is choking, care plans are updated with accurate care information, residents are positioned appropriately, Physician notification of blood sugars above specified parameters and weights are completed daily, if ordered. - Facility will implement daily rounds provided each business day by Management, to ensure residents are positioned properly -DNS/designee will review the 24 hour report to ensure blood sugars that are above the specified parameters that the Physician has been notified and that daily weights have been documented in the residents Medical Record **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; and by what date the systemic changes for each deficiency will be completed** **-** The DNS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 3 months, with results reported to the Quality Assurance and Performance Improvement Committee.	

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	A physician's order, dated 8/4/23, indicated the resident was to receive a regular diet, regular texture, and thin consistency. A physician's order, dated 9/14/23, indicated speech therapy to evaluate and treat oral dysphagia. A speech therapy note, dated 9/14/23, indicated the resident's diagnoses included, but were not limited to, dementia and dysphagia. The resident was referred to speech therapy for a swallowing assessment due to an increase in oral pocketing which placed the resident at an increased risk for aspiration and compromised airway protection. The clinical impression indicated the resident was recommended for treatment of dysphagia to facilitate airway protection and to maximize airway protection on the least restrictive diet. The resident's plan of care was not revised to include the swallowing concerns from the speech therapy note. A speech therapy note, dated 10/13/23, indicated the discharge recommendation were supervision for all meals with meal tray set up and to cut whole foods into bite sized pieces. The diet recommendation was for a regular texture and thin liquids. The resident's plan of care was not revised to include the swallowing concerns from the speech therapy note. A nursing progress note, dated 1/31/24 at 12:41 p.m., indicated the resident had to be reminded to chew and swallow the food she had left in her mouth once she made it to the television room.			

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	The care plans were reviewed and there was no care plan for dysphagia, food pocketing or the need to cut the resident's food into bite sized pieces. A witness statement obtained by the facility, dated 1/4/24, indicated RN 16 was called by a staff CNA due to Resident S being cyanotic (blue or purplish discoloration due to deficient oxygenation of the blood). The Heimlich maneuver was done by CNA 9 and a chewed piece of meat was dislodged. The resident's color changed to pale although there were still no respirations. The Heimlich was continued, and suction was done. The resident did not have respirations and the code status of DNR was verified. A witness statement obtained by the facility, dated 1/4/24, indicated CNA 17 was assisting the residents with lunch. CNA 17 heard another CNA ask if Resident S was okay. Resident S's face looked pale, and she was holding onto a walker. CNA 17 went to get a nurse. The nurses came into the dining room to assist, and CNA 17 assisted to take other residents out of the dining room to clear the area. A witness statement obtained by the facility, dated 1/4/24, indicated CNA 21 was in the dining room during lunch. A staff indicated Resident S was choking and CNA 21 saw CNA 9 had already started doing the Heimlich maneuver on the resident. A witness statement obtained by the facility, dated 1/5/24, indicated CNA 20 saw Resident S's face turn purplish and yelled for help. Another staff had started doing the Heimlich maneuver.			

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	A witness statement obtained by the facility, dated 1/5/24, indicated CNA 9 had been told Resident S was changing colors in her face. CNA 9 thought the resident was choking so CNA 9 started to do the Heimlich on the resident and kept doing the Heimlich. A witness statement obtained by the facility, dated 1/5/24, indicated Unit Manager (UM) 8 had arrived onto the unit and saw staff doing the Heimlich on Resident S. The crash cart was present, and suctioning was completed. The staff had suctioned food particles from the resident's mouth. The resident was nonresponsive, had no respiration, and no pulse. A witness statement obtained by the facility, dated 1/5/24, indicated UM 22 had entered the dining room on 1/4/24 and saw a CNA administering the Heimlich maneuver to Resident S. UM 22 helped the CNA to try to get the resident to cough the food up. CNA 22 was using the suction machine while the CNA continued to do the Heimlich. CNA 22 was able to get pieces of food and phlegm suctioned from the resident's mouth. The resident had no pulse and no respiration. The witness statements from RN 16, CNA 17, CNA 21, CNA 20, CNA 9, UM 8, and UM 22 did not include documentation to determine the staff had completed back blows in accordance with the Red Cross conscious choking protocol. During an interview, on 2/29/24 at 11:48 a.m., CNA 9 indicated, on 1/4/24, he was assisting another resident to eat. Speech Therapist (ST) 10 was in the dining room and indicated Resident S did not look right. Resident S stood up and looked like she was choking. CNA 9 got behind the resident and did the Heimlich. CNA 9 had both hands			

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	under the resident's breasts and was pushing up doing the Heimlich. One of the nurses had "the tube thing" to get the food out of the resident's mouth. ST 10 assisted to do the Heimlich. CNA 9 and ST 10 kept switching back and forth from behind the resident to push up her abdomen. CNA 9 indicated the resident's abdomen continued to be pushed up whether she was sitting or standing. The only time CNA 9 and ST 10 stopped pushing on the abdomen was when the nurse was using the suction machine. CNA 9 indicated the resident was going to eventually choke since she stuffed her mouth so much and was in a rush to eat. CNA 9 indicated he felt since the resident got regular food and stuffed her mouth, she should have received chopped up food. The food she got was too big. During an interview, on 2/29/24 at 12:09 p.m., RN 15 indicated CNA 9 said Resident S was choking and all the staff went into the dining room right away. RN 15 indicated she thought they had got the food out although the resident did not breathe again. CNA 9 did the Heimlich by pressing on the resident's abdomen. Then RN 15 tried to suction. There was food removed from the resident's mouth which looked like beef or bacon and it was one chunk about the size of a 50-cent piece. The resident had trouble chewing in the past. The resident would hold food in her mouth and the staff had to be careful to make sure she swallowed everything. During an interview, on 3/1/24 at 11:31 a.m., UM 8 indicated she was at the facility the day the resident choked. The staff was doing the Heimlich when UM 8 arrived at the unit. CNA 9 and another staff were switching back and forth to do the Heimlich. The resident was a DNR, so cardiopulmonary resuscitation (CPR) was not			

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	performed. The resident was sitting in the chair and the staff were leaning over the resident and doing abdominal thrusts. When CNA 9 was tired of doing the abdominal thrusts then the other person would do the abdominal thrusts. UM 8 was not familiar with the diet the resident was prescribed. UM 8 reviewed the electronic health record (EHR) and indicated the resident was on a regular diet, regular texture. The care plan only included setting up the meal tray and providing assistance as needed. The care plan did not have any other instructions for Resident S other than to assist with meals as needed. UM 8 indicated if the resident was at high risk while eating then there should be something on the care guide assignment sheet. During an interview, on 3/1/24 at 1:26 p.m., the ST 10 indicated Resident S had resided on the memory care and was nonverbal. ST 10 indicated she was one of the staff who was alternating doing the Heimlich with CNA 9. The Heimlich standard procedure was to grab the person around the waist and do upward thrusts. The resident's airway was completely obstructed. ST 10 saw a piece of food about the size of a dime. The resident was not able to manipulate a knife or fork to cut up food into bite size pieces. The resident had advanced dementia and had lost awareness of food in her mouth. Resident S ate way too fast and did not chew food adequately to safely swallow. She had the ability to chew although she did not have the cognitive awareness of food being present in her mouth and the need to grind to chew the food. ST 10 indicated she would not change the diet since there was a lot of pleasure with eating. The resident needed supervision since she did not have the cognition to recognize there was food in her mouth. ST 10 educated the charge nurse and			

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	the unit manager on the need to cut the food into small bites and to take small sips of fluid. A resident care guide, provided by the Assistant Director of Nursing (ADNS), on 3/1/24 at 2:32 p.m., indicated the resident needed to be toileted every 2 hours and was incontinent of bowel and bladder. The guide indicated Resident S required the total assistance of for ADLs (Activities of Daily Living). The resident was nonverbal although could understand when spoken to. The resident's care guide did not include interventions for supervision with meals or for cutting the resident's food into bite sized pieces. During an interview, on 3/1/24 at 2:39 p.m., UM 22 indicated, on 1/4/24, she saw a CNA doing the Heimlich maneuver on the resident. The CNA kept doing the Heimlich maneuver and the nursing staff grabbed the crash cart. The staff were able to get some of the food particles out of the resident's mouth, but not all of them. The food particles looked like corned beef and were less than half an inch in size. CNA 9 was doing the Heimlich and alternated with ST 10. The Heimlich maneuver was when CNA 9 stood behind the resident with his arms wrapped under her arms and was thrusting up under her breasts and under her sternum. The resident would rush to eat, and we would need to tell her to slow down and chew her food up. The staff had to empty her mouth out and one time she was sleeping and had food in her mouth. The resident had a mechanical soft diet for a while and then went back up to a regular diet. The daughter had requested no turkey sausage or bacon because the resident had trouble with those foods. The staff would only cut up the resident's food if they felt like it needed to be cut up.			

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	The staff interviews did not include information to determine CNA 9, ST 10, or RN 10 provided back blows during emergent care for choking for Resident S in accordance with the Red Cross conscious choking protocol. During an interview, on 3/1/24 at 3:18 p.m., RN 24 indicated she was the facility CPR instructor. The facility utilized the American Red Cross for First Aid and CPR training. The training for the adult choking victim included assessing the person for choking, then doing back blows and abdominal thrust and continue until the person could expel what was in their throat. Then call 911 and do CPR if unconscious. The staff were to start with 5 back blows, then 5 abdominal thrusts and continue to do back blows and abdominal thrusts until the person became unconscious and then do CPR if applicable. The American Red Cross did not use the word Heimlich anymore. The sequence was to use back blows then abdominal thrusts. During an interview, on 3/1/24 at 3:38 p.m., the ADNS and Administrator indicated the staff should use the method for a choking victim by using back blows and abdominal thrusts as taught at the facility. The Administrator indicated there was no documentation in the care plan or resident care guide to show the resident needed her food cut into bite sized pieces. A current policy, titled "First Aid," dated 10/2023 and received by the DNS on 3/6/24 at 5:05 p.m., indicated "...POLICY: See attached procedure from American Red Cross Manual for First Aid CPR and AED...." An "American Red Cross First Aid, CPR and AED Instructor Manual," not dated and received from the ADNS on 2/29/24 at 4:48 p.m., indicated			

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	"...Caring for a Choking Adult...Tell participants they will now practice giving back blows and abdominal thrusts to an adult...." A current policy, titled "Caring for Choking by the American Red Cross," not dated and received from the DNS on 3/6/24 at 5:05 p.m., indicated "...If the person is unable to speak, cry or cough, CALL 9-1-1 and get equipment, or tell someone to do so...Give 5 back blows...Position yourself to the side and slightly behind the choking person. Place one arm diagonally across a person's chest and bend them forward at the waist...Firmly strike the person between the shoulder blades with heel of your hand. Each back blow should be separate from the others...Give 5 abdominal thrusts...Have the person stand up and find their navel with two fingers. Move behind the person and place your front foot in between the person's feet with your knees slightly bent...Make a fist with your other hand and place the thumb side against the person's stomach right above your fingers. Cover your fist with your other hand...Pull inward and upward to give an abdominal thrust. Each abdominal thrust should be forceful and separate from the other...Alternatively, you may give chest thrusts to a person who is too large to wrap your arms around, pregnant or in a wheelchair...Continue giving sets of 5 back blows and 5 abdominal thrusts until...The person can cough forcefully, speak, cry or breathe...The person becomes unresponsive...If the person becomes unresponsive, gently lower them to the floor and begin, CPR, starting with compressions...After each set of compression and before attempting breaths, open the person's mouth, look for the object and, if seen, remove with a finger sweep...." 2. During an observation, on 2/27/24 at 2:11 p.m.,			

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	Resident V was sitting up in her Broda chair (chair for positioning) and her body was leaned to the left. She was trying to grasp a cup of water with her right hand and was not able to pick up the cup. During an observation, on 2/28/24 at 3:45 p.m., the resident was sitting up in her Broda chair in the common area at the end of hall 100, she was leaned towards the left side. There were no staff present in the common area. During an observation, on 3/5/24 at 11:10 a.m., the resident was sitting up in a high back wheelchair. Her head was leaning to the left almost touching the hand piece of the chair and there was a small pillow on the left side of the wheelchair which did not support the resident's head. During an observation, on 3/6/24 at 11:27 a.m., the resident was sitting up in a high back wheelchair, her head was leaning towards the left with her head tilted towards her chest. There was a pillow by her left arm tucked into the left side of the wheelchair. The pillow did not support the resident's head. During intermittent observations, the resident did not attempt to reposition herself in the Broda or high back wheelchair. The clinical record for Resident V was reviewed on 3/1/24 at 3:38 p.m. The diagnoses included, but were not limited to, systemic lupus, unspecified fracture of the right pubis (one of three bones which make up the hip bone), displaced fracture of the left femur, and unspecified dementia. A care plan, dated 11/17/23, indicated the resident had severely impaired cognitive function and			

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decision-making skills related to dementia. The interventions included, but were not limited to, cue, reorient, and supervise as needed.

A care plan, dated 4/5/23 and last revised on 12/1/23, indicated the resident had an activities of daily living (ADL) self-care performance deficit related to limited mobility, musculoskeletal impairment, pain from a history of a left femur fracture, and lack of coordination. The interventions included, but were not limited to, the resident required extensive staff assistance with turning and repositioning in bed and required extensive staff assistance with personal hygiene and oral care.

A care plan, dated 4/5/23 and last revised on 1/17/24, indicated the resident was at a high risk for falls related to balance, unaware of safety needs, and unsteadiness on feet. The interventions included, but were not limited to, anticipating, and meeting the resident's needs and a body pillow when in bed.

During an interview, on 3/6/24 at 11:27 a.m., CNA 5 indicated the resident did have a Broda chair, but the facility gave the chair back to the hospice provider. The resident was still able to pivot during a transfer and it was too difficult to get the resident out of the Broda chair. The resident favored the left side and even leaned towards the left while she was in bed. CNA 5 did not try to reposition the resident.

3. During an observation, on 2/28/24 at 3:53 p.m., Resident F was sitting up in her wheelchair, her head was tilted to the right. There was no positioning cushion in her wheelchair.

During an observation, on 2/29/24 at 11:44 a.m.,

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	the resident was sitting up in her wheelchair in the common area, her head was tilted to the right. There was a cushion on the bottom of her wheelchair and no other type of device in the chair. During an observation, on 3/1/24 at 11:12 a.m., the resident was sitting up in her wheelchair close to the common area. Her head was tilted to the right with her chin tilted towards her chest. There was no positioning cushion in her wheelchair. During an observation, on 3/4/24 at 3:48 p.m., the resident was sitting up in the common area and her head was leaning to the right. There was no positioning cushion in her wheelchair. During an observation, on 3/5/24 at 11:14 a.m., the resident was sitting up in the common area in her wheelchair. Her head was tilted down and there was a positioning cushion on the left side of her wheelchair. The clinical record for Resident F was reviewed on 3/1/24 at 3:04 p.m. The diagnoses included, but were not limited to, unspecified dementia, generalized muscle weakness, and unsteadiness in her feet. A physician's order, dated 4/25/23, indicated the resident was to always have a right lateral support in her chair to ensure an upright sitting position. An Occupational Therapy (OT) progress report, dated 4/12/23, indicated the resident was awaiting a neck brace to encourage proper seated alignment and the resident was given a high back chair with a right lateral support. A care plan, dated 6/27/21 and last updated on			

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	11/29/23, indicated the resident was at risk for altered range of motion to the bilateral lower extremities due to a diagnoses of muscle weakness and dementia which had progressed. The resident required restorative nursing to walk with a front wheeled walker and to perform trunk flexion before standing. The care plans did not include the resident's positioning and the need for a neck brace or a lateral support in her chair. During an interview, on 3/4/24 at 3:55 p.m., QMA 6, indicated she did not know what type of support the resident was supposed to have in her wheelchair. The resident did not have any support in her wheelchair. During an observation, on 3/4/24 at 3:56 p.m., with QMA 6, there was no type of lateral support located in the resident's room. During an interview, on 3/4/24 at 4:17 p.m., the Occupational Therapist (OT) 7 indicated the resident was seen by OT due to the resident leaning to one side. The lateral support was an L shaped cushion. OT 7 did not know what was going on with the cushion. At the time of exit, the facility did not provide a positioning and mobility policy.4a. The clinical record for Resident 99 was reviewed on 3/1/23 at 3:30 p.m. The diagnoses included, but were not limited to, diabetes mellitus (DM), congestive heart failure (CHF), and right above the knee amputee. A care plan, dated 2/27/23, indicated the resident had diabetes mellitus. The interventions included, but were not limited to, diabetes mellitus			

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	medications as ordered per the physician, and fasting serum blood sugar as ordered by the physician. A physician's order, dated 2/25/23, indicated to obtain blood sugars twice a day and notify the nurse practitioner or physician if the blood sugar was less than 70 or greater than 350. The following blood glucose levels were out of the physician call orders: a. On 11/11/23 at 5:53 p.m., the blood sugar level was 399. b. On 11/14/23 at 5:00 p.m., the blood sugar level was 385. c. On 2/19/24 at 5:18 p.m., the blood sugar level was 358. There was no documentation the physician was notified of the blood sugar out of the call parameter. 4b. A care plan, dated 2/27/23, indicated the resident had congestive heart failure. The interventions included, but were not limited to, monitoring weights daily as ordered. A physician's order, dated 10/13/23, indicated to notify the nurse practitioner or physician daily if the resident's weight was greater than 3 pounds in 24 hours or greater than 5 pounds in one week. The following daily weights were missing: a. The daily weights were missing on 11/7, 11/8, 11/11, 11/16, 11/17, 11/18, 11/24, 11/25, 11/27, 11/29 and 11/30/2023. b. The daily weights were missing on 12/1, 12/6, 12/7, 12/8, 12/9, 12/13, 12/14, 12/15, 12/17, 12/18, 12/21, 12/22, 12/23, 12/25, 12/28, 12/29 and 12/31/23.			

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	c. The daily weights were missing on 1/1, 1/6, 1/7, 1/8, 1/12, 1/13, 1/14, 1/15, 1/17, 1/18, 1/22, 1/23, 1/25, 1/28, 1/29 and 1/31/24. There was no documentation the physician was notified of the missing daily weights. During an interview, on 3/4/24 at 11:18 a.m., the ADNS indicated they did not have a CHF policy and the facility followed the weight policy for residents with CHF. During an interview, on 3/5/24 at 4:30 p.m., the DNS indicated the staff followed the physician's orders and called the physician if the blood glucose was above the call orders. The staff should follow the physician's order and get a daily weight and chart them. A current policy, titled "Glucose Testing," dated 1/2023 and received from the ADNS on 3/1/24 at 11:30 a.m., indicated "...To provide nursing staff with guidelines for the testing of residents glucose level...Verify the physician's orders for blood glucose testing...The nurse shall notify the physician of the results in accordance with physician's orders and/or facility protocols for hyper/hypoglycemia...." A current policy, titled "Physician Orders," dated as revised 3/2022 and received from the ADNS on 3/4/24 at 1:00 p.m., indicated "...All activities (medications, activities, lab orders, x-rays, diet, etc) that effect the resident shall be ordered by the physician/designee. No orders shall be changed or discontinued by anyone other than the physician/designee. Nursing shall follow all orders as written. If there is a question or concern, the physician/designee shall be contacted for clarification...."			

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	A current policy, titled "Weights," dated as revised 10/2023 and received from the ADNS on 3/1/24 at 11:30 p.m., indicated "...Residents shall be monitored for adequate nutritional status to ensure each one is able to maintain the highest practicable level of well-being...CHF Diagnoses: Weights for these residents are often performed on a daily basis as ordered by the physician. Any weight change of three (3) pounds (gain) in (24) twenty-four or five (5) pounds in a week shall be documented. The physician shall be notified of any weights changes that exceed the ordered parameters...." This citation relates to Complaints IN00425592. 3.1-37(a)			
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 interview and record review, the facility failed to determine the root cause and implement new interventions for falls for 1 of 8 residents reviewed for accidents. (Resident R) Finding includes: During an interview, on 2/29/24 at 9:29 a.m., Resident R's family member indicated the resident	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Unable to identify Resident R **How other residents having the**	04/02/2024

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	had several falls. The resident complained of weakness in both her arms and legs. The clinical record for Resident R was reviewed on 2/29/24 at 10:07 a.m. The diagnoses included, but were not limited to, vascular dementia with unspecified severity with agitation, insomnia, anxiety, and depression. A nursing progress note, dated 9/30/23 at 1:46 p.m., indicated the resident was found sitting on the floor in front of her bed. There was no documentation the Interdisciplinary Team (IDT) had reviewed the root cause or implemented a new intervention for the fall. A progress note, dated 9/30/23 at 11:22 p.m., indicated the resident was found on the bathroom floor. There was no documentation the IDT had reviewed the root cause or implemented a new intervention for the fall. A progress note, dated 10/1/23 at 3:40 p.m., indicated the resident was found on the floor in the resident's room. The resident's daughter was notified, and she wanted the resident taken off Zyprexa (an antipsychotic) due to the adverse effects and the possibility of permanent side effects. The daughter indicated the resident was feeling increased weakness in her arms and legs. A progress note, dated 10/5/23 at 6:20 p.m., indicated the resident was found on the floor next to bed in her room. There was no documentation the IDT had reviewed the root cause or implemented a new		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** - Education to be provided via inservicing by 4/1/2024. Education to include the Fall Management program -All residents have potential to be affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Education to be provided via inservicing by 4/1/2024. Education to include the Fall Management program - DNS/designee will review the 24hour report to review falls. IDT will discuss any falls and identify the Root Cause of the fall - Facility to provide on going training and skills validations for falls, as needed. **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; and by what date the systemic changes for each deficiency will be completed** **-** The DNS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 3 months,	

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	intervention for the fall. A care plan, dated 2/28/23, indicated the resident was a high risk for falls. The interventions included, but were not limited to, anticipating, and meeting the resident's needs, the nurse practitioner to do medication reviews, review information on past falls and attempt to determine cause of falls. Record possible root causes and remove any potential causes if possible. There were no documentation new interventions were added to the plan of care for the falls between 9/30/23 and 10/5/23. A care plan, dated 9/12/23, indicated the resident used anti-psychotropic medication. The interventions included, but were not limited to, monitor, document and report any adverse reactions and frequent falls. There were no documentation new interventions were added to the plan of care for the falls between 9/30/23 and 10/5/23. During an interview, on 3/6/24 at 3:41 p.m., the Assistant Director of Nurse Services (ADNS) indicated there was no IDT documentation for the falls or no new interventions. A current policy, titled "Fall Management Program," dated as revised 1/2023 and received by the ADNS on 3/6/24 at 5:05 p.m., indicated "...Residents will be protected from fall related injuries by providing a safe environment through environmental alterations and provision of interventions to reduce and/or eliminate internal/external risk factors ...Post Fall: Any resident experiencing a fall will be assessed immediately by the nurse assigned for possible		with results reported to the Quality Assurance and Performance Improvement Committee.	

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	injuries, any treatment required will be provided...All falls will be discussed by the Interdisciplinary Team (IDT) in the first meeting after the fall in order to determine the root cause of the fall and appropriate interventions. An IDT note shall be written by the responsible manager or designee and include the following information...Were previous interventions in place at the time of the fall. Root cause of the fall. New intervention to prevent future falls, if appropriate...." 3.1-45(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to label the oxygen tubing and to administer the correct liters of oxygen flow for 2 of 4 residents reviewed for respiratory care. (Resident 117 and 3) Findings include: 1. During an observation, on 2/27/24 at 12:55 p.m., Resident 117 was wearing an unlabeled nasal cannula tubing connected to a portable oxygen container. The humidity bottle for his oxygen condenser was also not dated.	F 0695	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 3 Oxygen tubing has been dated and or initialed Resident 117 no longer resides at the facility **How other residents having the potential to be affected by the**	04/01/2024

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	During an observation, on 2/28/24 at 10:13 a.m., Resident 117 was in bed with no oxygen being administered. The nasal cannula tubing and the humidity bottle were not labeled with the date it was last changed. During an observation, on 2/29/24 at 11:24 a.m., Resident 117 was asleep in bed. 1.5 liters of oxygen was being administered through a nasal cannula. During an observation, on 3/1/24 at 2:16 p.m., Resident 117 was asleep in bed. 1.5 liters of oxygen was being administered through a nasal cannula. During an observation, on 3/4/24 at 11:22 a.m., Resident 117 was wearing 2 liters of oxygen through an unlabeled nasal cannula tubing while sleeping in front of the television in the common area. During an observation, on 3/5/24 at 11:50 a.m., Resident 117 was asleep in bed. 1.5 liters of oxygen was being administered. During an observation, on 3/6/24 at 2:25 p.m., Resident 117 was asleep in bed. 1.5 liters of oxygen was being administered through an unlabeled nasal cannula tubing. The clinical record for Resident 117 was reviewed on 3/1/24 at 1:36 p.m. The diagnoses included, but were not limited to, pneumonia, malignant neoplasm of prostate, malignant neoplasm of skin, depression, and dementia. A care plan, initiated on 2/6/24, indicated Resident 117 had altered respiratory status and difficulty		**same deficient practice will be identified and what corrective action(s) will be taken;** All residents who used O2 therapy had their tubing checked to assure tubing had been changed and physician orders were compared to the setting being used to assure that the correct order was in place. An Inservice will be completed by 4/1/2024 educating staff on Oxygen Therapy to include proper dating/intialing the tubing and following the correct liter flow. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** An Inservice will be completed by 4/1/2024 educating staff on Oxygen Therapy to include proper dating/intialing the tubing and following the correct liter flow. -All residents with O2 therapy will have their tubing and setting checked every Tuesday to assure compliance with the physician's orders. **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; and by what date**	

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	breathing related to a history of pneumonia and hypoxia. It was last revised on 2/28/24. A physician's order, dated 2/15/24, indicated to change and date oxygen tubing weekly on Mondays. A physician's order, dated 2/15/24, indicated to change and date humidified water weekly on Mondays. A physician's order, dated 2/15/24, indicated to administer oxygen at 2 liters per nasal cannula each shift. A physician's progress note, dated 2/16/24, indicated the chief complaint was pneumonia. Resident 117 had recurrent pneumonia and a repeat chest x-ray showed moderate right pleural effusion (a buildup of fluid between the tissues which line the lungs and the chest) and right basilar airspace disease (air was replaced with fluid, pus, cells, or other material in the lungs). During an interview, on 2/28/24 at 10:15 a.m., LPN 1 indicated Resident 117 frequently took his oxygen off and the staff encouraged him to let them put it back on. LPN 1 indicated the oxygen tubing and humidifiers should be changed and labeled on Mondays.2. During an observation, on 2/27/24 at 12:34 p.m., Resident 3 was sitting in the dining room wearing oxygen at 2 liters via nasal cannula. The oxygen tubing was not dated or initialed. The concentrator oxygen tubing in the resident's room was not dated or initialed. The clinical record for Resident 3 was reviewed on 3/1/24 at 3:10 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), depression, hypertension,		**the systemic changes for each deficiency will be completed** The DNS/designee will be responsible for the completion of the F695 CQI Tool weekly for 8 weeks and then monthly for 3 months, with results reported to the Quality Assurance and Performance Improvement Committee.	

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	anxiety disorder, and neurocognitive disorder. A physician's order, dated 11/20/23, indicated to change and date oxygen tubing weekly on Monday's. During an interview, 2/27/24 at 12:28 p.m., CNA 13 indicated the tubing on the portable oxygen tank or concentrator were not dated or initialed. During an interview, on 2/27/24 at 12:45 p.m., RN 12 indicated oxygen tubing needed to be dated when it was put on. Monday night was when the tubing was replaced. During an interview, on 2/27/24 at 1:45 p.m., the 2A Unit Manager indicated the humidity bottle was dated but the oxygen tubing for the portable tank and concentrator did not have dates or initials. A current facility policy, titled "Oxygen Therapy," dated 1/2023 and received from the Assistant Director of Nursing on 2/27/24 at 3:30 p.m., indicated "...The licensed nurse is responsible to check oxygen level when making rounds to ensure physician orders and the actual setting are the same. The licensed nurse is responsible for the liter flow...The oxygen tubing needs to be changed weekly on Monday night shift...." 3.1-47(a)(6)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary			

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	instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview and record review, the facility failed to ensure medications were stored according to the pharmacy directions, were labeled and dated, and schedule II medication cards were not compromised for 4 of 5 carts reviewed for medication storage. (2A east, 2A west, 2B east and 2B west) Findings include: 1. During a medication cart observation on 2A east, on 3/1/24 at 9:40 a.m., there were 6 loose pills in the first drawer and 5 loose pills in the second drawer. 2a. During a medication cart observation on 2A west, on 3/1/24 at 9:37 a.m., with LPN 11, there was a brown plastic bag with an unopened bottle of	F 0761	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - 2A east, 2A west, 2B east and 2B west medication carts have been audited to ensure the schedule II medication cards are not comprised. -2A east medication cart has been audited to ensure there are no loose pills in the drawers **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	04/01/2024

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	Latanoprost Ophthalmic Solutions 0.005% eyedrops. A blue sticker on the plastic bag indicated the eyedrops should have been stored in the refrigerator until it was opened. There were 3 loose pills in the top drawer and 2 loose pills in the second drawer. 2b. The narcotic drawer contained the following: a. A medication card containing Norco 5-325 mg (milligram) tablets with one slot (slot 9) not sealed and containing a tablet. b. A medication card containing Lyrica 50 mg capsules with one slot (slot 6) not sealed and containing a capsule which had tape over the opening. c. A medication card containing Lyrica 50 mg capsules with 4 slots (slot 11, 10, 9 and 2) not sealed and containing a capsule which had tape over the opening. d. A medication card containing Lyrica 75 mg capsules with 1 slot (slot 21) not sealed and containing a capsule which had tape over the opening. e. A medication card containing Lyrica 100 mg capsules with 1 slot (slot 4) not sealed and containing a capsule which had tape over the opening. f. A medication card containing Lyrica 150 mg capsules with 1 slot (slot 18) not sealed and containing a capsule. g. A medication card containing Tramadol 50 mg tablets with 1 slot (slot 6) not sealed and containing a tablet. During an observation, on 3/1/24 at 10:54 a.m., the Unit Manager and an RN were observed destroying the whole card of narcotics which were observed to have been compromised and not just the pills in the slots which were was compromised.		**action(s) will be taken;** -No other residents have been affected. -Inservice to be completed by 4/1/2024 educating staff on Storage and Expiration, Dating of Medications, and Biologicals. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Inservice to be completed by 4/1/2024 educating staff on Storage and Expiration, Dating of Medications, and Biologicals -DNS/designee will do daily (Monday through Friday) medication cart audits to ensure schedule II medications are not compromised and that there are no loose pills in the drawers. **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; and by what date the systemic changes for each deficiency will be completed** **-** The DNS/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 3 months, with results reported to the Quality Assurance and Performance Improvement	

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	3. During a medication cart observation on 2B east, on 3/1/24 at 1:37 p.m., with LPN 17, there were labeled plastic bags containing Lumigan 0.01% eye drops, artificial tears, and atropine 1% eye drops. The bottles were open with no date when they were opened on the bottle or plastic bag containing the medication. The first and second drawers of the cart contained 11 loose various medications. 4. During a medication cart observation on 2B west, on 3/1/24 at 1:37 p.m., with LPN 18, the narcotic drawer contained the following: a. A medication card containing hydrocodone 5-325 mg tablets with 1 slot (slot 5) not sealed and containing a tablet. b. A medication card containing hydrocodone 5/325 mg tablets with 3 slots (slot 8, 13 and 21) not sealed and containing a tablet which had tape over the opening. c. A medication card containing hydrocodone 5/325 mg tablets with 1 slot (slot 5) not sealed and containing a tablet. During an interview, on 3/4/24 at 10:40 a.m., the RN indicated there should not be loose pills in the bottom of the drawers, and compromised pills should be destroyed. A current policy, titled "Medication Storage," with a revision date of 4/2022 and received from the Assistant Director of Nursing on 3/4/24 at 9:35 a.m., indicated "...drugs shall be stored in a clean and orderly manner in cabinets, drawers, or carts of sufficient size to prevent crowding...all schedule II drugs individually prescribed shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet or mobile drug storage unit...Medications requiring storage in a refrigerator shall be kept at		Committee.	

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	temperatures maintained between 36-46 degrees Fahrenheit...." A current policy, titled "Medication Administration," with a revision date of 4/2022 and received from the Assistant Director of Nursing on 3/1/24 at 11:30 a.m., indicated "...once a multi dose container is opened, the date opened shall be written on the label or container...." 3.1-25(g)(1) 3.1-25(k)(6) 3.1-25(n) 3.1-25(o) 3.1-25(p)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional			

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	standards for food service safety. Based on observation, interview and record review, the facility failed to keep stored food items covered in 1 of 1 cold storage room reviewed for safe and sanitary conditions in the kitchen. (cold storage room) Finding includes: During an initial kitchen tour, on 2/27/24 at 12:13 p.m., the cold storage room was reviewed. There was raw chicken observed which was sitting open to air and uncovered. During an interview, on 2/27/24 at 12:14 p.m., Dietary Manager 25 indicated the chicken should not be open to air. A current policy, titled "FOOD STORAGE FOOD SAFETY & INFECTION CONTROL 6.024," dated 9/7/22 and received from the Dietary Manager on 3/6/24 at 4:08 p.m., indicated "...All raw and prepared foods are to be covered, labeled, and dated when stored. Partially used food items in opened cans must be transferred to an appropriate storage container, covered, labeled, and dated...." A policy, titled "Storage Standards," received from Dietary Manager 25 on 3/6/24 at 4:08 p.m., indicated "...Ensure refrigerated and frozen TCS foods are properly stored...keep all items covered and loosely cover cooling items stored in a refrigerator...." 3.1-21(i)(3)	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - The chicken in the walk-in cooler was transferred from sheet trays into Lexan containers and properly covered **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;** -No residents have been affected. -Inservice to be completed by 4/1/2024 educating staff on food storage, food safety to include properly covering chicken **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Inservice to be completed by 4/1/2024 educating staff on food storage, food safety to include properly covering chicken -General Manager/designee will do daily (Monday through Friday) rounds to ensure chicken and or other food items are properly covered. **How the corrective action(s)**	04/01/2024

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed - The General Manager/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 3 months, with results reported to the Quality Assurance and Performance Improvement Committee.	
F 0880 SS=E 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			

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	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 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.			

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	§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. Based on observation, interview and record review, the facility failed to ensure infection control practices were in place for residents with transmission based precautions (TBP), to ensure staff performed hand hygiene, disinfected equipment, and used the appropriate personal protective equipment (PPE), to ensure infection control policies were reviewed and updated annually, and to ensure indwelling urinary catheter bags were not contaminated for 4 of 7 residents reviewed for infection control. (Resident Q, 14, 106 and 96) Findings include: 1. During an observation, on 2/28/24 at 10:53 a.m., Licensed Practical Nurse (LPN) 2 and Certified Nursing Aide (CNA) 3 entered the room of Resident Q to transfer her from the wheelchair to the bed. No hand hygiene was observed, and gowns were not put on as they entered the room. LPN 2 exited the room pushing the mechanical lift with her gloves in her hand and did not perform hand hygiene. There were no disinfecting wipes seen on the machine or in the room. LPN 2 passed the lift to LPN 1 to use in the next resident's room. Neither staff member was observed disinfecting the lift before it went down the hall and into another resident's room.	F 0880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** -Unable to identify Resident Q -Resident 14 no longer resides at the facility -When staff are performing high contact care for Resident 106 they are to wear disposable gowns. When care is completed the gown is to be disposed of in the trash -Resident 96's foley catheter is not touching the fall mat, the foley catheter is placed in a basin **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;** -All residents have the potential to be affected by alleged deficient practice. -An in-service will be completed by 4/1/2024 for all staff to include proper infection control practices regarding residents that are in	04/01/2024

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	During an interview, on 2/28/24 at 11:00 a.m., LPN 2 indicated Resident Q required enhanced barrier precautions (EBP) which meant the staff used gowns and gloves when in possible contact with the resident's urine due to something was found in her urine. During an interview, on 3/5/24 at 11:20 a.m., LPN 1 and CNA 3 indicated Resident Q was on EBP for an extended spectrum beta-lactamase producing organism (ESBL) which could not be killed by many common antibiotics. The staff wore gowns when they were going to have direct contact with her urine, like incontinent care and changing her brief. LPN 1 indicated the staff were to clean equipment after each resident using disinfecting wipes and were to perform hand hygiene after each resident. The clinical record for Resident Q was reviewed on 3/1/24 at 03:44 p.m. The diagnoses included, but were not limited to, extended spectrum beta lactamase (ESBL) resistance, multiple sclerosis, bipolar, and dementia. A care plan, initiated on 8/10/23, indicated Resident Q required enhanced barrier precautions related to ESBL and the staff were to wear gowns and gloves when providing incontinence care. A physician's order, dated 3/7/23, indicated Resident Q was in enhanced barrier precautions related to ESBL. "Proper PPE (gown and gloves) should be worn while high-contact resident care activities are being performed." 2. During an observation, on 3/5/24 at 11:38 a.m., two (2) reusable isolation gowns were hanging on hooks at the door in the room of Resident 14. Social Services 23 was sitting on the resident's		Transmission based precautions (TBP), hand hygiene, disinfecting equipment and the use of appropriate personal protective equipment (PPE), and indwelling urinary catheter bags. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** --An in-service will be completed by 4/1/2024 for all staff to include proper infection control practices regarding residents that are in Transmission based precautions (TBP), hand hygiene, disinfecting equipment and the use of appropriate personal protective equipment (PPE), and indwelling urinary catheter bags -IP/designee will complete 10 observations per week using the hand hygiene tool -IP/designee will complete 10 observations per week using the PPE observation tools -IP/designee will do rounds (Monday-Friday) to ensure Foley Catheter's are not touching the floor and ensure equipment is being cleaned properly -IP/designee will provide ongoing training, oversight, resources and competencies as needed. **How the corrective action(s)**	

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	bed with no gown on. The clinical record for Resident 14 was reviewed on 3/5/24 at 3:44 p.m. The diagnosis included, but was not limited to, extended spectrum beta lactamase (ESBL) resistance. A physician's order, dated 12/15/23, indicated Resident 14 was in enhanced barrier precautions related to ESBL. "Proper PPE (gown and gloves) should be worn while high-contact resident care activities are being performed." A care plan, initiated on 8/10/23, indicated Resident 14 had ESBL in her urine and required enhanced barrier precautions. 3. During an observation, on 3/5/24 at 11:40 a.m., a single isolation gown was hanging on a hook in the room of Resident 106. The clinical record for Resident 106 was reviewed on 3/5/24 at 4:00 p.m. The diagnoses included, but were not limited to, ESBL resistance. A physician's order, dated 1/19/24, indicated Resident 106 was in enhanced barrier precautions related to ESBL. "Proper PPE (gown and gloves) should be worn while high-contact resident care activities are being performed." A care plan, initiated on 1/29/24, indicated Resident 106 had ESBL in her urine and required enhanced barrier precautions. During an interview, on 3/6/24 at 10:15 a.m., Unit Manager 8 indicated staff reused the reusable isolation gowns during their shift and then sent them to the laundry at the end of their shift unless they were visibly soiled. They did not reuse		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** - The IP/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 3 months, with results reported to the Quality Assurance and Performance Improvement Committee.	

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	disposable gowns. During an interview, on 3/6/24 at 11:20 a.m., the Assistant Director of Nursing Services (ADNS) indicated the facility had instructed the staff to reuse isolation gowns for a single shift for all precautions if the gowns were reusable. Disposable gowns were not to be reused. 4. The facility policies, titled "Hand Hygiene," "Infection Prevention System of Surveillance," "Antibiotic Stewardship Program," "Influenza Immunization-Residents," "Pneumococcal Vaccine," "Covid-19 Vaccination-Residents," and "Medical Devices/Supplies-Cleaning," were all dated as last reviewed on 1/2023. During an interview, on 3/6/24 at 11:20 a.m., the ADNS indicated the received policies were up-to-date and currently used by the facility infection control program.5. During an observation, on 2/27/24 at 2:15 p.m., Resident 96's catheter bag touched the fall mattress on the ground next to the resident's bed. During an observation, on 2/28/24 at 10:36 a.m., Resident 96's catheter bag was still touching the fall mattress. During an observation, on 3/5/24 at 11:35 a.m., CNA 25 was stepping on the resident's fall mattress. The clinical record for Resident 96 was reviewed on 2/29/24 at 3:51 p.m. The diagnoses included, but were not limited to, retention of urine, history of urinary tract infection, and obstructive and reflex uropathy. A physician's order, dated 12/19/23, indicated the			

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	155001	A. BUILDING 00 B. WING	03/06/2024

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	resident may have a urinary catheter related to retention of urine. A current care plan, dated 8/8/23, indicated a current intervention was to place a fall mattress on the floor of the open side of the resident's bed. During an interview, on 2/28/24 at 10:38 a.m., Unit Manager 8 indicated the catheter should not be touching the fall mattress or the ground. A current policy, titled "Urinary Drainage Bag/ Tubing Care," dated as revised in July of 2022 and received from the DON (Director of Nursing) on 3/6/2024 at 5:05 p.m., indicated "...The drainage bag shall be attached to the bed frame so that it does not touch the floor...." A current policy, titled "Hand Hygiene," dated as approved on 1/2023 and received from the Administrator upon entrance, indicated hand hygiene was to be performed "...before having direct contact with a resident and/or equipment...before entering a resident's room, after leaving a resident's room...before and after removing gloves..." A current policy, titled "Enhanced Barrier Precaution," dated as approved on 10/2023 and received from the ADNS on 2/29/24 at 3:45 p.m., indicated "...Enhanced Barrier Precautions (EBP) requires the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (Multi drug resistant organisms) to staff hands and clothing...Examples of high-contact resident care activities include: 1. Dressing 2. Bathing/showering 3. Transferring 4. Providing Hygiene 5. Changing linens 6. Changing briefs or assisting with toileting...."			

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	The CDC website page, https://www.cdc.gov/niosh/topics/pandemic/strategies-gowns, dated as revised on May 9, 2023 and accessed on 3/7/24 at 5:45 p.m., indicated "...disposable gowns generally should NOT be reused, and reusable gowns should NOT be reused before laundering, because reuse poses risks for transmission among HCP (healthcare personnel) and patients that likely outweigh any potential benefits...gown reuse has the potential to facilitate transmission of organisms among patients...repeatedly donning and doffing a contaminated gown may increase risk for HCP self-contamination." Reusing gowns were part of crisis and contingency PPE availability strategies during a pandemic and had not been found in routine strategies prior to the pandemic crisis. 3.1-18(b) 3.1-18(l)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Nursing Home Complaints IN00420378, IN00425592 and IN00428227. Complaints IN00420378 - No deficiencies related to the allegations are cited. Complaints IN00425592 - Federal/State deficiencies related to the allegations are cited at F676, F677, F679 and F684.	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 the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 4/1/2024.	

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	Complaints IN00428227 - No deficiencies related to the allegations are cited. Survey dates: February 27, 28, 29 and March 1, 4, 5 and 6, 2024. Facility number: 000001 Residential Census: 19 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on March 14, 2024.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to keep stored food items covered in 1 of 1 cold storage room reviewed for safe and sanitary conditions in the kitchen. (cold storage room) Finding includes: During an initial kitchen tour, on 2/27/24 at 12:13 p.m., the cold storage room was reviewed. There was raw chicken observed which was sitting open to air and uncovered. During an interview, on 2/27/24 at 12:14 p.m., Dietary Manager 25 indicated the chicken should not be open to air. A current policy, titled "FOOD STORAGE FOOD	R 0273	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - The chicken in the walk-in cooler was transferred from sheet trays into Lexan containers and properly covered **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;** -No residents have been affected. -Inservice to be completed by	04/01/2024

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	SAFETY & INFECTION CONTROL 6.024," dated 9/7/22 and received from the Dietary Manager on 3/6/24 at 4:08 p.m., indicated "...All raw and prepared foods are to be covered, labeled, and dated when stored. Partially used food items in opened cans must be transferred to an appropriate storage container, covered, labeled, and dated...." A policy, titled "Storage Standards," received from Dietary Manager 25 on 3/6/24 at 4:08 p.m., indicated "...Ensure refrigerated and frozen TCS foods are properly stored...keep all items covered and loosely cover cooling items stored in a refrigerator...."		4/1/2024 educating staff on food storage, food safety to include properly covering chicken **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Inservice to be completed by 4/1/2024 educating staff on food storage, food safety to include properly covering chicken -General Manager/designee will do daily (Monday through Friday) rounds to ensure chicken and or other food items are properly covered. **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; and by what date the systemic changes for each deficiency will be completed** **-** The General Manager/designee will be responsible for the completion of the CQI Tool 5 x/ week for 4 weeks, then weekly for 3 months, with results reported to the Quality Assurance and Performance Improvement Committee.	
R 0295	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance			

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Bldg. 00	(a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview and record review, the facility failed to ensure a resident's medication was able to be locked and secured for 1 of 1 resident observed who self-administered medications. (Resident 311) Finding includes: During an observation, on 3/4/24 at 11:36 a.m., Resident 311 was sitting in her living room. The resident indicated she administered her own medications. There was a bottle of medication sitting on the counter next to the refrigerator. She indicated the facility never gave her anything with a lock to put her medication in. The resident's dead bolt on her main door had been broken for two months. The clinical record for Resident 311 was reviewed on 3/1/23 at 3:30 p.m. The diagnoses included, but were not limited to, depressive disorder, congestive heart failure, hypertension, diabetes mellitus, and atrial fibrillation. During an interview, on 2/28/24 at 10:10 a.m., the Director of Assisted Living indicated the dead bolt on the resident's door was not working correctly. The door did not lock, and the inside of the deadbolt lock was missing a piece. A current policy, titled "Medication Administration-Self Administration Evaluation," dated as revised 9/2019 and received by the Director of Nursing Services on 3/5/24 at 10:35 p.m., indicated "...If it is the decision to not allow the resident to administer their mediations, then all	R 0295	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident 311's medications are locked and secured **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;** -No other residents have been affected. -Inservice to be completed by 4/1/2024 educating staff on Storage and Expiration, Dating of Medications, and Biologicals. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Inservice to be completed by 4/1/2024 educating staff on Storage and Expiration, Dating of Medications, and Biologicals -Clinical Director/designee will do weekly audits to ensure medications are locked and secured. **How the corrective action(s)**	04/02/2024

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	medication shall be removed from the resident's room and kept in the nursing station...."		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** - The Clinical Director/designee will be responsible for the completion of the CQI Tool weekly X's 4 weeks then monthly X's 3, with results reported to the Quality Assurance and Performance Improvement Committee.	