STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155508	A. BUILDING 00 B. WING	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE	725 S SECOND ST BOONVILLE, IN 47601

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00428375. Complaint IN00428375 - Federal/State deficiencies related to the allegations are cited at F623 and F625. Survey dates: March 4, 5, 6, 7, 8, 11, 12, 13, 14, 2024 Facility number: 000451 Provider number: 155508 AIM number: 100266240 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type: Medicare: 12 Medicaid: 39 Other: 1 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 22, 2024.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective April 12, 2024 to the state findings of the Recertification, State Licensure and Complaint Survey conducted on March 14, 2024.	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robin L McCarty	Executive Director	04/05/2024

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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	including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure each resident was treated with dignity for 3 of 3 residents reviewed for dignity and 2 random observations.	F 0550	F - 550 *1.) The corrective action taken for those residents found to have been affected by the deficient*	04/12/2024

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	Two residents had catheter bags that were not covered. A resident was walking down the hall with wet pants and another with debris on her face and shirt. A resident asked for breakfast tray to be removed but it was not. (Resident 203, Resident 27, Resident 29, Resident 101, Anonymous Resident) Findings include: 1. On 3/4/24 at 9:32 A.M., Resident 203 was observed laying in her bed with an uncovered catheter bag hanging on the left side of her bed with dark amber urine in it that was visible from the hallway. On 3/6/24 at 8:25 A.M., Resident 203 was observed laying in bed with an uncovered catheter bag hanging on the left side of her bed with light amber urine in it visible from the hallway. On 3/11/24 at 9:10 A.M., Resident 203 was observed laying in bed with an uncovered catheter bag hanging on the left side of her bed with light yellow urine in it visible from the hallway. On 3/5/24 at 12:56 P.M., Resident 203's clinical record was reviewed. Diagnoses included multiple sclerosis and neurogenic bladder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 1/29/24, indicated Resident 203 was cognitively intact and an extensive assist of 2 staff for bed mobility, totally dependent on 2 staff for transfers and toileting, and extensive assist of 1 staff for eating. Current Physician's Orders included, but were not		*practice is that* the resident identified as resident 203 now has their catheter drainage bag covered at all times. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as 101 now has their face cleaned following each meal and/or snack. Resident 101 also now has their clothes changed promptly when soiled. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as 29 now has their catheter drainage bag covered at all times. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as 27 has now been placed on a toileting program. The resident wears incontinent briefs and is promptly changed when soiled. All soiled furniture is properly cleaned and disinfected when incontinent episodes occur. *5.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as anonymous now has each meal tray promptly removed when they are finished with their meal. The nurse identified as RN 9 has been re-educated on their	

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	limited to, the following: May anchor suprapubic (inserted through a small incision or hole in your abdomen used to drain urine from the bladder) catheter, ordered 2/28/24 A current Catheter Care Plan, revised 11/16/23, included, but was not limited to, the following intervention: Position catheter bag and tubing below the level of the bladder and away from entrance room door, initiated 10/7/22 During an interview on 3/12/24 at 12:26 P.M., the Assistant Director of Nursing (ADON) a catheter bag should be covered if it can be seen from the hallway. 2. On 3/4/24 at 9:42 A.M., Resident 101 was observed walking down the hall and in the common area with a yellow substance on her mouth and chin. On 3/13/24 at 8:10 A.M., Resident 101 was observed walking down the hall and passed the nurses station with a brown substance on her mouth, chin, and the front of her shirt. 3. On 3/4/24 at 12:01 P.M., Resident 29 was observed sitting in a wheelchair in the dining room with several other residents and staff waiting for lunch. A catheter bag was observed hanging from the back of the wheelchair, uncovered. 4. During an observation on 3/4/24 at 12:08 P.M., Resident 27 walked out of the dining room full of residents. At that time, his pants were saturated on his crotch and right thigh down to his knee. During an observation on 3/5/24 at 10:25 A.M., CNA (Certified Nurse Aide) 18 walked down the		responsibility to remove the residents' meal trays upon the resident's request or when finished with the meal. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. All residents with catheters now have their urinary drainage bags covered at all times. All residents promptly have any food debris promptly removed and clothes changed when soiled. All residents now have their meal trays removed when finished with their meals or when requested. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's dignity policy. The staff was reminded to ensure that all residents are dressed in clean clothes, clothing changed with soiled, and food debris promptly removed. The staff was also reminded to ensure that all urinary drainage bags are covered at all times and that all reasonable resident requests are promptly honored by staff, such as removal of meal trays. F – 550 (continued) *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a	

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	hallway with Resident 27. Resident 27's pants were saturated on his crotch and right thigh down to his knee. During an observation on 3/5/24 at 10:27 A.M., the chair in the dining room Resident 27 sat in had a large wet area on the cushion. During an interview on 3/8/24 10:33 A.M., LPN (Licensed Practical Nurse) 21 indicated Resident 27 would not have been able to tell staff that he was wet. During an interview on 3/8/24 at 12:50 P.M., CNA 18 indicated staff would be expected to assist a resident to clean up if a wet spot was observed on them, and she was unsure if the chair had been cleaned. 5. During an interview on 3/5/24 at 9:31 A.M., an anonymous Resident indicated that staff failed to remove the breakfast tray from the bedside table until lunch trays are delivered. On 3/5/24 at 9:35 A.M., RN (Registered Nurse) 9 was asked to remove the Resident's breakfast tray. During an observation on 3/5/24 at 9:52 A.M., the Resident's breakfast tray continued to be on the bedside table. At that time, RN 9 was sitting at the nurse's station. During an interview on 3/8/24 at 10:41 A.M., the ADON (Assistant Director of Nursing) indicated staff should remove the meal trays from the rooms 30 minutes after the trays are delivered. During an interview on 3/12/24 at 10:48 A.M., RN 9 indicated if staff is requested to remove a tray from a room, it should be delegated to another		Quality Assurance tool has been developed and implemented to ensure that each resident is treated with dignity and respect. The tool will monitor the use of urinary drainage bag covers, the resident's appearance to ensure they are clean and well-groomed and that all reasonable requests are promptly honored. This tool will be completed by the Social Service Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	staff member or be removed within 5 minutes. A current nondated Dignity Policy was provided by the Administrator on 3/11/24 at 10:55 A.M., and indicated "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem ... Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered ... " 3.1-3(a) 3.1-3(t) 3.1-32(a)			
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 residents that were self administering medications were assessed for capability to self administer medications for 1 of 1 residents observed with medications in their rooms. (Resident F) Finding includes: During an observation on 3/4/24 at 9:39 A.M., Resident F was observed in bed and had a clear medication cup on her bedside table that had 7 circular tablets in it. At that time, the resident indicated staff left Tums in her room for her upset stomach.	F 0554	F – 554 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident F has had a new self-administration of medication assessment completed. All medications have been removed from resident F's room and nursing administers all medication. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all	04/12/2024

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	During an observation on 3/5/24 at 9:22 A.M., Resident F had an unlabeled albuterol sulfate inhaler on her bedside table. At that time, Resident F indicated she used the inhaler twice a day. On 3/5/24 at 1:01 P.M., Resident F's clinical record was reviewed. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 1/29/24, indicated Resident F had moderate cognitive impairment. Current diagnoses included, but were not limited to, heart failure, hypertension, anxiety disorder, and depression. A current Self Medication assessment, dated 2/26/24, indicated, "...Resident has no deesire [sic] or is totally unable to self administer medication..." The clinical record lacked a current Physician's Order for Tums. The clinical record lacked a current Physician's Order for albuterol sulfate. Current care plans included, but were not limited to, "[name of resident] has GERD [gastroesophageal reflux disease]," revised 4/28/23. Current interventions included, but was not limited to, "Give medications as ordered. Monitor/document side effects and effectiveness..." The clinical record lacked a care plan related to use of inhaler. During an interview on 3/8/24 at 9:51 A.M., LPN (Licensed Practical Nurse) 21 indicated that Resident F did not have any medications that she self administered.		residents have the potential to be affected by this deficient practice. An audit has been completed on all residents to identify any resident who is capable and requests to self-administer medications/treatments. An audit of all residents' rooms has been completed and there are no medications/treatments at bed side except for those residents who have been deemed capable and request to self-administer medications/treatments. A care plan has been developed for any resident who has been approved to self-administer any medication/treatment. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses and QMAs on the facility's policy related to self-administration of medications. The nurses and QMAs have been instructed that no medications/treatments are to be left at bedside without the supportive self-administration of medication assessment and physician's orders. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the self-administration of medications. The tool will monitor	

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	During an interview on 3/12/24 at 10:49 A.M., RN (Registered Nurse) 9 indicated resident F should not have any medications in her room and staff should stay with the resident during a medication pass. At that time, she indicated she was unsure why she had an inhaler in her room. On 3/13/24 at 12:50 P.M., the ADON (Assistant Director Of Nursing) provided an undated Self-Administration of Medications policy that indicated, "...4. If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications..." 3.1-11(a)		to ensure that the appropriate self-administration of medication assessment, along with the appropriate physician's orders to self-administer medications has been completed for those residents capable and who wish to self-administer medications. The tool will also monitor to ensure that medications/treatments that are to be self-administered are stored securely in the residents' rooms. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);			

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	(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on observation, interview, and record review, the facility failed to ensure appropriate parties were notified following a change in resident condition for 1 of 3 residents reviewed for	F 0580	F - 580 *1.) The corrective action taken for those residents found to have been affected by the deficient*	04/12/2024

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	nutrition and 1 random observation. The physician, Registered Dietician (RD), nor a representative were notified following a significant weight loss, and the physician was not notified of a resident's use of an electronic cigarette. (Resident 7, Resident J) Findings include: 1. During a random observation on 3/5/24 at 10:49 A.M., Resident 7 was observed lying in bed using an electronic cigarette. On 3/7/24 at 11:45 A.M., Resident 7 indicated her son used to bring her two electronic cigarettes per week, but that was too much, so she asked him to bring her less, and now received one per week. She indicated her roommate had recently moved out of the room, and she used her electronic cigarette to celebrate. She also indicated she never got out of bed, and used the electronic cigarette in bed. On 3/7/24 at 8:48 A.M., Resident 7's clinical record was reviewed. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease, Alzheimer's disease, dementia, and depression. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 12/23/23, indicated no cognitive impairment, and no behaviors. Resident 7's clinical record lacked an assessment, care plan, and physician orders for use of an electronic cigarette. On 3/12/24 at 10:14 A.M., the Assistant Director of Nursing (ADON) indicated staff had taken an electronic cigarette from Resident 7 the week prior, and should have notified the physician at that time, but had not.		*practice is that* education has been provided for the resident identified as resident 7 related to safe smoking and facility policy. The resident agreed to quit smoking. Smoking cessation education was provided for the resident and the resident declined any interventions. The physician and responsible representative have been advised of the resident's choice. All smoking materials have been removed from the resident's room. The resident will continue to be monitored by nursing and social service related to any complications/issues. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident J has been reviewed by the dietitian and nutritional supplements have been added as warranted. The physician and the resident's representative have been notified of the resident's current weight issues as well as any nutritional interventions being provided for the resident. The resident's nutritional care plan has been updated as well. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit has been	

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	Resident 7's clinical record was reviewed again on 3/14/24 at 10:02 A.M. and lacked notification to the physician related to the use of an electronic cigarette. 2. On 3/5/24 at 9:01 A.M., Resident J's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, depression, and schizophrenia. The most recent Quarterly MDS Assessment, dated 2/6/24, indicated cognition status could not be obtained. Resident 12 had no weight loss or weight gain, and no swallowing or dental concerns. Resident J's clinical record lacked current physician orders related to weights. A current risk for altered nutrition and hydration care plan dated 4/28/17 included, but was not limited to, an intervention to weigh resident monthly or as physician ordered, dated 3/13/20. A current risk for fluid imbalance care plan dated 9/17/22 included, but was not limited to, an intervention to document abnormal findings and notify the physician, dated 9/17/22. Resident J's weights included, but were not limited to, the following: 4/14/23 245.0 pounds 11/17/23 214.3 pounds (a 12.53% decrease from 4/14/23) 2/1/24 194.0 pounds (a 9.47% decrease from 11/17/23) A nutrition/dietary note from the RD on 11/28/23 at 1:59 P.M. indicated Resident J's weight was reviewed at that time.		conducted to identify any recent changes in a resident's condition. All recent changes in the residents' conditions have been promptly reported to their physician as well as their representative and documented in their respective clinical records. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses, QMAs and social services as to the facility policy on notification of changes in the resident's condition/status. Staff members were re-educated on their responsibility to notify the physician and the residents' representative of any and all changes in the residents' condition/status and to document these notifications in the clinical record. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the clinical record to ensure that all changes in the residents' condition/status have been reported to the physician and the resident's representative per facility policy. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then	

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	155508	A. BUILDING 00 B. WING	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE	725 S SECOND ST BOONVILLE, IN 47601

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	A care conference note from the Social Services Director (SSD) on 2/1/24 at 1:45 P.M. indicated the resident and Power of Attorney (POA) were present and discussed the chart, care plan, and preferences with no changes to note. The care conference note did not indicate Resident J's weights had been reviewed. On 3/13/24 at 12:48 P.M., the ADON indicated Resident J's physician, RD, or representative had not been notified of the significant weight loss on 11/17/23 or 2/1/24. On 3/13/24 at 12:48 P.M., the ADON provided a current non-dated Change in a Resident's Condition or Status policy that indicated "Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status ... The nurse will notify the resident's attending physician or physician on call when there has been a(an) ... accident or incident involving the resident ... significant change in the resident's physician/emotional/mental condition" On 3/13/24 at 12:50 P.M., the ADON provided a current non-dated Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol policy that indicated "The staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake" 3.1-5(a)(1) 3.1-5(a)(2)		quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of			

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	abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to report an allegation of misappropriation of medications for 1 of 1 residents reviewed for missing medications. A finding of missing controlled substances was not reported to the State Survey Agency. (Resident J) Findings include: On 3/5/24 at 9:01 A.M., Resident J's clinical record	F 0609	F - 609 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident J has had their narcotic administration documentation reviewed. The narcotic count matches the narcotic control count sheet and	04/12/2024

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	was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, depression, and schizophrenia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 2/6/24, indicated cognition status could not be obtained. Resident J had received antipsychotic, antianxiety, antidepressant, antibiotic, diuretic, and opioid medications. Current physician orders included, but were not limited to, the following: Clonazepam 0.5 mg (milligram) at bedtime for anxiety, dated 1/30/24. Resident J's MAR (medication administration record) for January 2023 indicated clonazepam 0.5 mg was administered on 1/25/24 by Qualified Medication Aide (QMA) 25 during a hospitalization when the resident was not in the facility. On 3/11/24 at 9:50 A.M., the Assistant Director of Nursing (ADON) was made aware of the discrepancy found in Resident J's medication administration. On 3/11/24 at 10:04 A.M., Resident J's Controlled Substance Accountability form was reviewed for the administration of clonazepam 0.5 mg. The forms did not match the MAR administration of medications, with 2 doses missing on 1/31/24. On 3/13/24 at 8:52 A.M., the Administrator indicated Resident J's alleged missing medications had not been reported because the ADON had investigated and determined that no medications had been missing, as it was only an error in documentation. On 3/13/24 at 9:20 A.M., Resident J's Controlled		no medications are missing. Any future misappropriation of medications will be promptly reported to the required agencies. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all narcotic control sheets was conducted and compared to the current physician's orders and MARs. There was no misappropriation of any missing medications identified during this audit. Any misappropriation of medications that are identified in the future will be promptly reported to the appropriate agencies. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the administrator and nursing administration on the facility policy to reportable occurrences. The staff was instructed on their responsibility to promptly report any misappropriation of resident's medications to the required agencies as mandated by the regulation. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to	

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	Substance Accountability forms were reviewed with the ADON. At that time, she indicated the incident should have been reported, as there were missing medications that still needed to be investigated more thoroughly. On 3/13/24 at 1:35 P.M., the ADON provided a current non-dated Unusual Occurrence Reporting policy that indicated "Our facility will report the following events to appropriate agencies ... Allegations of abuse, neglect and misappropriation of resident property ... Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations" 3.1-28(c)		monitor the documentation on the administration of controlled substances to ensure there are no discrepancies in the physician's orders, the medication administration record and the narcotic count sheets. The tool will monitor to ensure that the resident is receiving their controlled substances in accordance with the physician's orders and that the narcotic counts are correct. The tool will also monitor to ensure that there is documentation to support that any discrepancies in the administration of a controlled substance has been promptly reported to the required agencies. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse,			

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	neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to perform a thorough and complete investigation of an alleged incident for 1 of 1 residents reviewed for missing medications. A finding of missing medications was not thoroughly investigated after being reported to the facility. (Resident J) Findings include: On 3/5/24 at 9:01 A.M., Resident J's clinical record was reviewed. Admission date was 6/2/23. Diagnosis included, but were not limited to, dementia, anxiety, depression, and schizophrenia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 2/6/24, indicated cognition status could not be obtained. Resident J had received antipsychotic, antianxiety, antidepressant, antibiotic, diuretic, and opioid medications. Physician orders included, but were not limited to, the following: Clonazepam 0.5 mg (milligram) at bedtime for anxiety, dated 1/30/24 (current order). Resident J's MAR (medication administration record) for January 2023 indicated clonazepam 0.5mg was administered on 1/25/24 by Qualified	F 0610	F - 610 *The corrective action taken for those residents found to have been affected by the deficient practice is that* a thorough investigation has now been completed for the alleged missing medications belonging to resident J. No additional issues were identified. Upon audit of the current clinical record, no additional missing medications were identified. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all residents has been conducted to determine if there are any additional incidents that need to be investigated. No additional incidents have been identified that require any investigations. *The measures that have been put into place to ensure that the deficient practice does not recur is*	04/12/2024

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	Medication Aide (QMA) 25 while the resident was in the hospital. On 3/11/24 at 9:50 A.M., the Assistant Director of Nursing (ADON) was made aware of the discrepancy found in Resident J's medication administration. On 3/11/24 at 10:04 A.M., Resident J's Controlled Substance Accountability form was reviewed for the administration of clonazepam 0.5 mg. The forms did not match the MAR administration of medications, with 2 doses missing on 1/31/24. On 3/11/24 at 10:56 A.M., the ADON indicated QMA 27 had given Resident J the noon dose of clonazepam on 1/22/24 just before leaving for the hospital. At that time, the ADON was unaware that the clonazepam had been documented as given on the Controlled Substance Accountability form, and documented as not given on the resident's MAR. On 3/12/24 at 8:29 A.M., the ADON indicated QMA 25 had told her she must have checked off on giving Resident J a dose of clonazepam on 1/25/24 without actually giving the medication, as she was going from one resident to the next signing off on what was due on the MAR. On 3/13/24 at 8:52 A.M., the Administrator indicated she did not have record of the investigation and that the ADON had investigated Resident J's alleged missing medications, spoke with the nurses that signed off on them, and they all told her they had marked them accidentally. To her knowledge, the investigation had been complete. On 3/13/24 at 8:57 A.M., the ADON indicated the		*that* a mandatory in-service has been provided for the administrator and nursing administration on the facility's policy related to the required investigating of events. The staff was instructed on their responsibility to ensure all incidents are thoroughly investigated as required by the regulation. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor all alleged incidents to ensure that all incidents have been thoroughly investigated in accordance with the regulation. The tool will monitor to ensure that all appropriate witnesses have been interviewed and the finding documented. The tool will also monitor to ensure that all parts of the event have been thoroughly reviewed in an effort to determine exactly what occurred and who if anyone was responsible for the event that occurred as well as the appropriate action taken one the outcome of the investigation has been determined. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine	

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	investigation into the alleged missing medications was complete and determined that the nurses had been clicking too fast on the resident's MAR and clicked off as being given, although it had not been. On 3/13/24 at 9:20 A.M., Resident J's Controlled Substance Accountability forms were reviewed with the ADON. At that time, she indicated no other forms could be located to account for what happened to the missing medications and a more thorough investigation needed to be done to determine what happened, as there were 2 doses that should be left that were not given. She indicated at that time the incident should have been reported, and staff educated. On 3/13/24 at 10:30 A.M., Clinical Support indicated since the bottom of the count sheet indicated 2 doses had been destroyed, it was only an error on the nurses part by signing off on the sheet for 1/31/24 at 6:00 A.M. and 12:00 P.M. At that time, she indicated she thought the nurse that signed off on the medications was Licensed Practical Nurse (LPN) 5, but not certain. On 3/13/24 at 10:53 A.M., LPN 5 indicated it was his signature on Resident J's Controlled Substance Accountability form on 1/31/24 at 6:00 A.M. and 12:00 P.M. He indicated he did not remember exactly what happened, but if it was signed off as being taken out of the cart, he must have pulled it and given it to the resident. On 3/13/24 at 1:35 P.M., a current non-dated Accidents and Incidents - Investigating and Reporting policy was provided and indicated "All accidents or incidents involving residents, employees, visitors, etc., occurring on our premises shall be investigated and reported to the		if any additional action is warranted.	

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	administrator" 3.1-28(d)			
F 0623 SS=E Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently			

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	to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone			

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	number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review, the facility failed to ensure a notice of transfer or discharge was given to residents or resident representatives for 7 of 9 residents reviewed for hospitalizations. The transfer discharge form was not completed. There was no documentation of a resident, representative, and the ombudsman receiving a notice of transfer or discharge at the time of hospitalization. (Resident B, Resident C, Resident E, Resident F, Resident G, Resident H, Resident J) Findings include: 1. On 3/5/24 at 1:01 P.M., Resident F's clinical record was reviewed and indicated they were	F 0623	F - 623 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident F will have a completed transfer/discharge form provided for them and/or their representative upon any future transfers/discharges from the facility. The ombudsman will also be notified of the transfer/discharge and this notification will be documented in the clinical record.	04/12/2024

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	admitted from the facility to the hospital on 2/9/24 and returned back to the facility from the hospital on 2/11/24. Resident F's records lacked a notice of transfer/ discharge. On 2/9/24 at 5:45 P.M., a progress note in Resident F's clinical record indicated, "Transfer/Discharge Information Late Entry:...How was notice of transfer/discharge and bed hold policy given?...in person..." On 3/12/24 at 9:43 A.M., the MDS (Minimum Data Set) Coordinator provided a Notice of Transfer or Discharge form, dated 2/9/24 that was not filled out for Resident F. 2. On 3/6/24 at 10:58 A.M., Resident E's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, dysphagia, stroke, right side hemiplegia (paralysis of one side of the body). The most recent Quarterly MDS Assessment, dated 2/16/24 indicated Resident E's cognition was moderately impaired, was totally dependent on 2 staff for bed mobility, transfers, toileting and extensive assist of 1 staff for eating. Progress notes included, but were not limited to, the following: On 1/22/24 at 10:30 A.M., "Alert Note: Resident showing signs of possible aspiration: Lungs sound somewhat wet on the right side. Also has low grade fever of 100.5 ... Notified NP [nurse practitioner], order to send to Deaconness Gateway for evalution ... " On 1/22/24 at 12:02 A.M., "Social Services Note:		*2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident E will have a completed transfer/discharge form provided for them and/or their representative upon any future transfers/discharges from the facility. The ombudsman will also be notified of the transfer/discharge and this notification will be documented in the clinical record. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident C no longer resides at the facility. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident B no longer resides at the facility. *5.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident J will have a completed transfer/discharge form provided for them and/or their representative upon any future transfers/discharges from the facility. The ombudsman will also be notified of the transfer/discharge and this notification will be documented in the clinical record.	

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	155508	A. BUILDING 00 B. WING	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE	725 S SECOND ST BOONVILLE, IN 47601

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	SSD [Social Services Director] notified guardian of [resident name] being flu A positive and being sent to hospital. Questions answered. No concerns. " The clinical record lacked documentation of the resident and representative receiving a notice of transfer and discharge at the time of hospitalization. On 3/7/24 at 3:04 p.m., the State Long-Term Care Ombudsman Program Deputy Director indicated she did not receive transfer and discharge paperwork for Resident E's 1/22/24 hospitalization. 3. On 35/24 at 1:56 P.M., Resident C's clinical record was reviewed and indicated they were admitted from the facility to the hospital on 11/25/23 and returned back to the facility from the hospital on 12/4/23. Progress note from 11/25/23 failed to indicate if Bed Hold/Notice of Transfer was forwarded to Ombudsman. On 3/7/24 at 3:04 P.M., an email from the Deputy Director from the State LTC (Long Term Care) Ombudsman Program indicated a monthly report was received for Resident C for the 11/25/23 hospitalization late. It was not reported until Feb., 2024. 4. On 3/12/24 at 10:02 A.M., Resident B's clinical record was reviewed and indicated they were admitted from the facility to the hospital on 2/12/2024. There was no date for Resident B returning to the facility. On 2/12/2024 at 8:57 A.M., Transfer/Discharge Information in the Progress Notes indicated Bed Hold/Notice of Transfer information to be		*6.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident G will have a completed transfer/discharge form provided for them and/or their representative upon any future transfers/discharges from the facility. The ombudsman will also be notified of the transfer/discharge and this notification will be documented in the clinical record. *7.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident H no longer resides at the facility. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit was conducted on all residents who have been transferred/discharged from the facility within the past thirty days. Each resident that has been transferred/discharged from the facility in the past thirty days, now has a completed Notice of Transfer/Discharge form in their clinical record and the facility has supportive documentation to reflect that the ombudsman has been notified of the transfer/discharge.	

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	forwarded to Ombudsman was sent with resident. 5. On 3/6/24 at 11:49 A.M., Resident J's clinical record was reviewed. Resident J was sent to the hospital on 7/18/23 and 1/22/24. Resident J's clinical record lacked documentation that a transfer/discharge form had been sent with the resident or to a resident representative for either hospitalization. 6. On 3/5/24 at 1:50 P.M., Resident G's clinical record was reviewed. Resident G was sent to the hospital on 1/24/24. Resident G's clinical record lacked a transfer/discharge form for the 1/24/24 hospitalization. 7. On 3/8/24 at 9:38 A.M., Resident H's clinical record was reviewed. Resident H was sent to the hospital on 10/13/23, 11/6/23, 12/7/23, 12/25/23, 1/5/24, 1/13/24, and 1/18/24 with the following transfer/discharge information: 10/13/23 Transfer/discharge form not filled out or scanned in the clinical record 11/6/23 Transfer/discharge form not filled out 12/7/23 Transfer/discharge form not filled out 12/25/23 Transfer/discharge form not filled out 1/5/24 Ombudsman not notified of the transfer/discharge 1/13/24 Transfer/discharge form not given to resident or representative. Ombudsman not notified of the transfer/discharge		F – 623 (continued) *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses, QMAs and the social service director on the facility's policy related to the required documentation to be provided to the resident and/or their representative at the time of transfer/discharge from the facility. The social service director was also re-educated on their responsibility for notifying the ombudsman of all transfers/discharges as well as the required supportive documentation of this notification. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the required documentation per facility policy of any and all transfers/discharges. The tool will monitor to ensure there is supportive documentation in the clinical record that the Notice of Transfer/Discharge form along with a copy of the facility's bed hold policy has been completed and is provided for the resident and/or their representative at the time of each transfer/discharge from the facility. The tool will also monitor	

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	On 3/11/24 at 9:30 A.M., a current non-dated Transfer or Discharge, Facility-Initiated policy was provided and indicated "Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care [LTC] ombudsman when practicable ..." This citation relates to Complaint IN00428375. 3.1-12(a)		to ensure there is supportive documentation that the ombudsman has been notified of each resident's transfer/discharge from the facility. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0625 SS=E Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section,			

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	permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to ensure a bed hold policy was given to residents or resident representatives for 5 of 9 residents reviewed for hospitalizations. The bed hold form was not completed. There was no documentation of a resident or representative receiving a bed hold at the time of hospitalization. (Resident C, Resident E, Resident F, Resident G, Resident H, Resident J) Findings include: 1. On 3/5/24 at 1:01 P.M., Resident F's clinical record was reviewed and indicated they were admitted from the facility to the hospital on 2/9/24 and returned back to the facility from the hospital on 2/11/24. Resident F's records lacked a bed hold policy. On 2/9/24 at 5:45 P.M., a progress note in Resident F's clinical record indicated, "Transfer/Discharge Information Late Entry:...How was notice of transfer/discharge and bed hold policy given?...in person..." On 3/12/24 at 9:43 A.M., the MDS (Minimum Data Set) Coordinator provided a bed hold policy form, dated 2/9/24 that was not filled out for Resident F.	F 0625	F - 625 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident F and/or their representative will be provided a copy of the facility's bed hold policy upon any future transfer/discharge from the facility. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident E and/or their representative will be provided a copy of the facility's bed hold policy upon any future transfer/discharge from the facility. In addition, the ombudsman will also be notified of the facility's bed hold policy upon any future transfer/discharge of the resident. 3.) *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident C no longer	04/12/2024

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	2. On 3/6/24 at 10:58 A.M., Resident E's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, dysphagia, stroke, right side hemiplegia (paralysis of one side of the body). The most recent Quarterly MDS Assessment, dated 2/16/24 indicated Resident E's cognition was moderately impaired, was totally dependent on 2 staff for bed mobility, transfers, toileting and extensive assist of 1 staff for eating. Progress notes included, but were not limited to, the following: On 1/22/24 at 10:30 A.M., "Alert Note: Resident showing signs of possible aspiration: Lungs sound somewhat wet on the right side. Also has low grade fever of 100.5 ... Notified NP [nurse practitioner], order to send to [name of hospital] for evaluation ... " On 1/22/24 at 12:02 A.M., "Social Services Note: SSD [Social Services Director] notified guardian of [resident name] being flu A positive and being sent to hospital. Questions answered. No concerns. " The clinical record lacked documentation of the resident or representative receiving a notice of bed hold policy at the time of hospitalization. On 3/7/24 at 3:04 p.m., the State Long-Term Care Ombudsman Program Deputy Director indicated she did not receive bed hold paperwork for Resident E's 1/22/24 hospitalization.3. On 3/05/24 at 1:56 P.M., Resident C's clinical records were reviewed and indicated they were admitted from the facility to the hospital on 1/10/24 and returned back to the facility from the hospital on 1/17/24.		resides at the facility. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident J and/or their representative will be provided a copy of the facility's bed hold policy upon any future transfer/discharge from the facility. *5.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident G and/or their representative will be provided a copy of the facility's bed hold policy upon any future transfer/discharge from the facility. *6.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident H no longer resides at the facility. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all clinical records was conducted to identify any resident who had been transferred or discharged from the facility within the past thirty days. All identified transfer/discharged residents and/or their representatives have received a copy of the facility's bed hold	

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	Resident C's records lacked a bed hold policy given to the resident or a representative at the time of the transfer. On 3/11/24 at 10:55 A.M., the Administrator provided a Notice of Transfer and Bed Hold paperwork that was not filled out. The Transfer/Discharge Notice section and the Reason for Transfer or Discharge section was not completed. 4. On 3/6/24 at 11:49 A.M., Resident J's clinical record was reviewed. Resident J was sent to the hospital on 7/18/23 and 1/22/24. Resident J's clinical record lacked documentation that a bed hold policy form had been sent with the resident or to a resident representative for either hospitalization. 5. On 3/5/24 at 1:50 P.M., Resident G's clinical record was reviewed. Resident G was sent to the hospital on 1/24/24. Resident G's clinical record lacked a bed hold policy form for the 1/24/24 hospitalization or information that it had been provided to the resident or resident representative. 6. On 3/8/24 at 9:38 A.M., Resident H's clinical record was reviewed. Resident H was sent to the hospital on 10/13/23, 11/6/23, 12/7/23, 12/25/23, 1/5/24, 1/13/24, and 1/18/24 with the following bed hold policy information: 10/13/23 Bed hold policy form not filled out or scanned in the clinical record. 11/6/23 Bed hold policy form not filled out.		policy upon transfer/discharge from the facility. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses, QMAs and social service director on the facility's bed hold policy. The staff was instructed on their responsibility to ensure a copy of the bed hold policy was provided for the resident and/or their representative upon transfer/discharge from the facility as well as their responsibility to ensure there is supportive documentation in the clinical record of this notification. F – 625 (continued) *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the clinical record to ensure there is supportive documentation to reflect that the resident and/or their representative receives a copy of the facility bed hold policy upon transfer/discharge from the facility. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be	

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	12/7/23 Bed hold policy form not filled out. 12/25/23 Bed hold policy form not filled out. 1/5/24 Ombudsman not notified of the transfer/discharge. 1/13/24 Bed hold policy form not given to resident. Ombudsman not notified of the transfer/discharge. On 3/11/24 at 9:30 A.M., a current non-dated Bed-Holds and Returns policy was provided and indicated "All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence ... Residents, regardless of payer source, are provided written notice about these policies ..." This citation relates to Complaint IN00428375. 3.1-12(a)(25) 3.1-12(a)(26)		reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0641 SS=E Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure MDS (Minimum Data Set) Assessments were accurate for 6 of 23 residents reviewed for MDS Assessments. Medications were not accurately documented. (Resident E, Resident J, Resident 13, Resident 30, Resident 34, Resident 203) Findings include:	F 0641	F - 641 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a modified MDS has been completed and submitted with the identified corrections for the resident identified as resident 34.	04/12/2024

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	1. On 3/07/24 at 2:44 P.M., Resident 34's clinical record was reviewed. Resident 34 was admitted on 9/29/21. Diagnoses included, but were not limited to, Type II diabetes mellitus with foot ulcer, chronic atrial fibrillation, major depressive disorder, chronic kidney disease, and dementia. The most current State optional, Quarterly MDS (Minimum Data Set) Assessment, dated 2/2/24 indicated Resident 34 had severe cognitive impairment, required total dependence of two for bed mobility, transfers and toilet use and total dependence of one for eating. The medications listed were insulin 7 days, antianxiety, anticoagulant, opioid, and hypoglycemic. Physician Orders included, but were not limited to the following: lorazepam Oral Tablet 1 MG (Milligram) Give 1 tablet by mouth two times a day related to dementia, dated 3/5/2024 glipizide XL (Extended Release) Oral Tablet 10 MG Give 1 tablet by mouth one time a day related to Type II diabetes mellitus with foot ulcer, dated 2/13/2024 Novolog FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Milliliter) Inject as per sliding scale: if 0 - 150 = 0; 151 - 200 = 6; 201 - 250 = 8; 251 - 300 = 10; 301 - 350 = 12; 351 - 400 = 14 If greater than 400 give 14 u (units) and call MD (Doctor of Medicine) for further orders., subcutaneously before meals and at bedtime for prophylaxis related to Type II diabetes mellitus with foot ulcer sliding scale qhs (every bedtime), dated 11/26/2023 Norco Oral Tablet 5-325 MG Give 1 tablet by		*2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a modified MDS has been completed and submitted with the identified corrections for the resident identified as resident J. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a modified MDS has been completed and submitted with the identified corrections for the resident identified as resident 13. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a modified MDS has been completed and submitted with the identified corrections for the resident identified as resident E. *5.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a modified MDS has been completed and submitted with the identified corrections for the resident identified as resident 30. *6. The corrective action taken for those residents found to have been affected by the deficient practice is that* a modified MDS has been completed and submitted with the identified corrections for the resident identified as resident 203.	

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	mouth two times a day for pain, dated 11/22/2023 aspirin Oral Capsule 81 MG Give 1 capsule by mouth one time a day related to chronic atrial fibrillation, dated 7/25/2023 Basaglar KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML Inject 18 unit subcutaneously two times a day related to Type II diabetes mellitus with foot ulcer. May administer after resident eats meal, If refuses meal may hold, started 12/4/2023, discontinued 2/12/2024 Eliquis Tablet 5 MG Give 0.5 tablet by mouth two times a day related to chronic atrial fibrillation, dated 8/17/2022 On 3/07/24 at 2:44 P.M., review of the MAR (Medication Administration Record) indicated Resident 34 received aspirin 81 mg daily from 1/26/24 to 2/2/24. The MDS did not list an antiplatelet in the medications. During an interview on 3/13/24 at 11:30 A.M., MDS Coordinator indicated she did not see in the October changes that aspirin was to be added to medications under antiplatelets. 2. On 3/6/24 at 11:49 A.M., Resident J's clinical record was reviewed. Diagnosis included, but was not limited to, dementia and anxiety. The most recent MDS (Minimum Data Set) Assessment, dated 2/6/24, indicated cognitive status could not be obtained. The MDS indicated the resident had received an antibiotic. Resident J's physician orders lacked an order for an antibiotic around the time of the most recent MDS on 2/6/24. Resident J's medication administration record		*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of each resident's most recent MDS has been conducted to ensure all information in the MDS is accurate for that specific time frame. All identified corrections have now been made and the MDSs resubmitted. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the MDS coordinator and all members of the interdisciplinary team on their responsibility to ensure that all information has been entered accurately on the MDS based on the resident's current condition/status in accordance with the RAI manual. F – 641 (continued) *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the accuracy of the information submitted in the	

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	(MAR) lacked an antibiotic given during the 7-day look back for the 2/6/24 MDS Assessment. On 3/14/24 at 10:09 A.M., the MDS Coordinator indicated she could not find where Resident J had received an antibiotic prior to the 2/6/24 MDS Assessment, and that information had been entered in error. 3. On 3/4/24 at 8:32 A.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, hypertension and diabetes mellitus. The most recent Quarterly MDS, dated 1/27/24, indicated Resident 13 received insulin 1 day during the 7 day look back period. Resident 13's clinical record lacked a current order for insulin. During an interview on 3/11/24 at 1:40 P.M., the MDS Coordinator indicated insulin was documented on the MDS since Resident 13 received Trulicity (non-insulin) once a week. 4. On 3/6/24 at 10:58 A.M., Resident E's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, dysphagia, stroke, right side hemiplegia (paralysis of one side of the body). The most recent Quarterly MDS Assessment, dated 2/16/24, indicated Resident E's cognition was moderately impaired, was totally dependent on 2 staff for bed mobility, transfers, toileting, wears glasses, and was not taking an antiplatelet medication during the 7 day look back period. Current Physician's Orders included, but were not limited to, the following: Aspirin 81 MG (milligram) tablet, give 1 tablet by mouth one time a day for heart health, ordered 8/17/23		MDS. The tool will monitor to ensure that each section of the MDS contains accurate information based on the resident's current status/condition. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	155508	A. BUILDING 00 B. WING	03/14/2024

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	The February 2024 MAR (medication administration record) was reviewed and indicated Resident 1 was administered Aspirin 81 mg on the following dates: 2/11/24 2/13/24 2/14/24 2/15/24 2/16/24 During an interview on 3/12/24 at 1:28 P.M., the MDS Coordinator indicated she was under the impression that Aspirin was not coded as antiplatelet on MDS Assessment and she was unsure if Resident E had glasses but will check into it. During an interview on 3/13/24 at 10:13 A.M., the MDS Coordinator indicated Resident E doesn't have glasses and it was an error on the MDS Assessment. 5. On 3/4/24 at 12:15 P.M., Resident 30 was observed walking with a cane down the West Hall to his room without staff's assistance. On 3/5/24 at 10:43 A.M., Resident 30 was observed laying in his bed, got up, and walked with a cane into the hallway without staff's assistance. On 3/11/24 at 9:12 A.M., Resident 30 was observed walking with a cane through the dining room to the West Hall nurse's station without staff's assistance. On 3/11/24 at 9:28 A.M., Resident 30's clinical record was reviewed. Diagnoses included, but were not limited to, depression and anxiety.			

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	The most recent Admission MDS Assessment, dated 2/2/24, indicated Resident 30 was cognitively intact and an extensive assist of 1 staff for bed mobility, transfers, eating and toileting. A current ADL performance (Activities of Daily Living) Care Plan, revised 2/23/24, included, but was not limited to the following interventions: bed mobility: assist of 1, initiated 1/26/24 transfers: assist of 1, initiated 1/26/24 eating: assist of 1, initiated 1/26/24 toileting: assist of 1, initiated 1/26/24 During an interview on 3/13/24 at 10:25 A.M., the MDS Coordinator indicated he refused to get out of bed when MDS Assessment was completed so they weren't sure of his functional abilities. She indicated he was doing better now and was able to transfer and use the bathroom by himself with staff supervision. 6. On 3/5/24 at 12:56 P.M., Resident 203's clinical record was reviewed. Diagnoses included, but were not limited to, multiple sclerosis. The most recent Quarterly MDS Assessment, dated 1/29/24, indicated Resident 203 was cognitively intact and an extensive assist of 2 staff for bed mobility, totally dependent on 2 staff for transfers and toileting, and extensive assist of 1 staff for eating, and Resident 203 had no impairments of her upper or lower extremities. Current Physician's Orders included, but were not limited to, the following: May use Hoyer lift for transfers as resident tolerates, ordered 12/14/23			

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	Turn and reposition approximately every 2 hours per braden scale every shift, ordered 10/7/22 A current Self Care Deficit Care Plan, revised on 1/30/24, included, but was not limited to, the following interventions: transfers: staff to assist with transfers at all times, initiated 10/7/22 transfers: Resident 30 utilizes assistive device mechanical stand lift with staff assist, initiated 10/7/22 During an interview on 3/11/24 at 10:05 A.M., the Assistant Director of Nursing (ADON) indicated Resident 203 did have both upper and lower extremity impairments, she can't use legs and she has some mobility of her arms but it's limited. During an interview on 3/12/24 at 1:18 P.M., the MDS Coordinator indicated she will look into extremity impairments and what classifies them as yes or no according to the RAI (Resident Assessment Instrument) manual. During an interview on 3/12/24 at 1:18 P.M., the MDS Coordinator indicated there was not an MDS Assessment policy, they use the RAI manual.			
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and			

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	psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			

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	Based on observation, interview, and record review, the facility failed to develop and implement person-centered care plans and interventions specific to resident needs for 4 of 18 residents reviewed for care plan development. An intervention for monthly weights was not followed, a care plan was developed with inaccurate diagnosis, care plans were not developed for residents on antiplatelets and antianxiety medication. (Resident J, Resident G, Resident 41, Resident 34) Findings include: 1. On 3/5/24 at 9:01 A.M., Resident J's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, depression, and schizophrenia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 2/6/24, indicated cognitive status could not be obtained. Resident J had no weight loss or gain, and no swallowing or dental concerns. Resident J lacked current physician orders related to weights. A current risk for altered nutrition and hydration care plan dated 4/28/17 indicated, but was not limited to, an intervention to weigh resident monthly or as physician ordered. Resident J's weights from April 2023 through current included the following: 4/14/2023 245.0 Lbs 1/5/2023 260 Lbs 7/13/2023 218.2 Lbs 11/17/2023 214.3 Lbs 1/3/2024 198.8 Lbs 2/1/2024 194.0 Lbs 2/6/2024 193.0 Lbs	F 0656	F - 656 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident J has now had their care plan reviewed and revised as warranted. The care plan interventions are now being followed related to weighing the resident in accordance with their plan of care. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident G has now had their care plan reviewed and revised as warranted. The care plan now addresses and has appropriate interventions in place to address all pertinent diagnoses listed in the resident's clinical record. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 34 has now had their care plan reviewed and revised to include a care plan for the use of an anticoagulant and an antianxiety medication. Appropriate interventions to address these concerns are now in place and being followed by staff. *4.) The corrective action taken for those residents found to have been affected by the deficient*	04/12/2024

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	3/1/2024 194.0 Lbs On 3/13/24 at 9:40 A.M., Clinical Support indicated Resident J's weights should have been completed monthly per the care plan. 2. On 3/5/24 at 1:50 P.M., Resident G's clinical record was reviewed. Diagnosis included, but was not limited to, epilepsy. The most recent Annual MDS Assessment, dated 3/5/24, indicated no cognitive impairment and no behaviors. The MDS Assessment did not indicate dementia, anxiety, depression, bipolar disorder, psychotic disorder, or schizophrenia. A current care plan was in place for a diagnoses of intellectual disability, epilepsy, generalized anxiety disorder, major depression, psychotic disorder, and adjustment disorder with depressed mood, dated 7/11/23. A current care plan was in place for a diagnoses of personality disorder, mild cognitive impairment, adjustment disorder, schizoaffective disorder, bipolar disorder, dementia, and major depressive disorder, dated 3/5/24. An admission record dated 6/2/23 indicated, but was not limited to, the following diagnosis: epilepsy intellectual disabilities depression adjustment disorder with depressed mood A PASARR (preadmission screening and resident review) form, dated 6/14/23, indicated the following diagnosis: generalized anxiety disorder major depression psychotic disorder		*practice is that* the resident identified as resident 41 no longer resides at the facility. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all resident care plans has been completed to ensure all identified issues or concerns for the resident have been care planned and appropriate interventions have been put in place which are being followed by facility staff members. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been conducted for all members of the interdisciplinary team on the facility's policy related to development of person-centered comprehensive care plans. The staff was re-educated on their responsibility to ensure that all concerns/conditions/concerns of each resident are to be care planned with appropriate individualized interventions developed and followed by all staff members. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the resident care plans to	

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	adjustment disorder On 3/12/24 at 9:50 A.M., the MDS Coordinator indicated there were several diagnosis for Resident G that were listed on a provider note that were historical and that was why the care plan was put in related to those diagnosis. At that time, the physician progress note was reviewed with the MDS Coordinator. The note dated 3/25/23 indicated, but was not limited to, the following diagnosis: adjustment disorder with depressed mood intellectual functioning disability The form indicated, but was not limited to, the following under "problems" last reviewed 11/14/22: anxiety disorder intellectual functioning disability psychotic disorder hallucinations On 3/13/24 at 10:25 A.M., the Assistant Director of Nursing (ADON) indicated it was the facility policy to have person-centered care plans and follow interventions included in care plans. 3. On 3/07/24 at 2:44 P.M., Resident 34's clinical record was reviewed. Resident 34 was admitted on 9/29/21. Diagnoses included, but were not limited to, Type II diabetes mellitus with foot ulcer, chronic atrial fibrillation, major depressive disorder, chronic kidney disease, and dementia. The most current State optional, Quarterly MDS (Minimum Data Set) Assessment, dated 2/2/24 indicated Resident 34 had severe cognitive impairment, required total dependence of two for bed mobility, transfers and toilet use and total dependence of one for eating. The medications listed were insulin 7 days, antianxiety, anticoagulant, opioid, and hypoglycemic.		ensure that all concerns/issues/conditions have been appropriately addressed and that the interventions are consistently being followed by all staff members. This tool will be completed by the MDS Coordinator and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	Physician Orders included, but were not limited to the following: lorazepam Oral Tablet 1 MG (Milligram) Give 1 tablet by mouth two times a day related to dementia, dated 3/5/2024 glipizide XL (Extended Release) Oral Tablet 10 MG Give 1 tablet by mouth one time a day related to Type II diabetes mellitus with foot ulcer, dated 2/13/2024 Novolog FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Milliliter) Inject as per sliding scale: if 0 - 150 = 0; 151 - 200 = 6; 201 - 250 = 8; 251 - 300 = 10; 301 - 350 = 12; 351 - 400 = 14 If greater than 400 give 14 u (units) and call MD (Doctor of Medicine) for further orders., subcutaneously before meals and at bedtime for prophylaxis related to Type II diabetes mellitus with foot ulcer sliding scale qhs (every bedtime), dated 11/26/2023 Norco Oral Tablet 5-325 MG Give 1 tablet by mouth two times a day for pain, dated 11/22/2023 aspirin Oral Capsule 81 MG Give 1 capsule by mouth one time a day related to chronic atrial fibrillation, dated 7/25/2023 Basaglar KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML Inject 18 unit subcutaneously two times a day related to Type II diabetes mellitus with foot ulcer. May administer after resident eats meal, If refuses meal may hold, started 12/4/2023, discontinued 2/12/2024 Eliquis Tablet 5 MG Give 0.5 tablet by mouth two times a day related to chronic atrial fibrillation, dated 8/17/2022			

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	The clinical record lacked care plans for antiplatelet and anxiety medication use. 4. On 3/5/24 at 1:27 P.M., Resident 41's clinical records were reviewed. He was admitted on 12/7/23. Diagnosis included, but was not limited to cerebral infarction, chronic embolism and thrombosis of bilateral lower extremities, chronic pain due to trauma, depression, atherosclerotic heart disease of native coronary artery. The most current State optional, Quarterly MDS Assessment, dated 1/29/24, indicated Resident 41 was cognitively intact, and needed extensive assistance of one for bed mobility, transfer, eating and toilet use. The medications listed were antianxiety, antidepressant, antibiotic, opioid, anticoagulant, and antiplatelet. Physician Orders included, but were not limited to the following: Norco Oral Tablet 7.5-325 MG (Milligrams) Give 1 tablet by mouth every 6 hours as needed for pain related to chronic pain due to trauma, dated 2/27/2024 Cymbalta Oral Capsule Delayed Release Particles 60 MG Give 1 capsule by mouth one time a day related to depression, dated 2/27/2024 trazodone HCl (hydrochloride) Oral Tablet 150 MG Give 1 tablet by mouth at bedtime related to depression, dated 2/7/2024 clopidogrel bisulfate Tablet 75 MG Give 1 tablet by mouth one time a day for blood clot prevention related to personal history of pulmonary embolism, dated 12/8/2023			

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	apixaban Oral Tablet 5 MG Give 1 tablet by mouth two times a day related to personal history of pulmonary embolism, dated 12/7/2023 Levaquin (antibiotic) 750 mg Give one daily for seven days, dated 1/25/24 buprenorphine Oral Tablet 8 mg Give 0.5 tablet sublingually every six hours for chronic pain due to trauma, dated 12/8/23 Ativan Oral Tablet 0.5 mg Give 1 tablet every 12 hours as needed for anxiety, dated 1/4/24 discontinued 1/31/24 hydrocodone-acetaminophen Oral Tablet 5-325 mg Give 1 tablet every six hours as needed for chronic pain due to trauma, dated 1/10/24 discontinued 1/24/24 The clinical record lacked care plans for antiplatelet and anxiety medication use. During an interview on 3/12/24 at 2:36 P.M., the MDS Coordinator indicated a resident on an antiplatelet and anticoagulant should have separate care plans for each medication. She indicated a resident on medication for anxiety should have a care plan for anxiety. On 3/11/24 at 10:55 A.M., the Administrator provided an undated Care Plans, Comprehensive Person-Centered Policy which indicated, " 1. The interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. the comprehensive, person-centered care plan is developed with seven days of the completion of the required MDS Assessment, and no more than			

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	155508	A. BUILDING 00 B. WING	03/14/2024

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	21 days after admission..." 3.1-35(a)			
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview, and record review, the facility failed to ensure each resident's person-centered, comprehensive care plan was reviewed and revised for 3 of 21 residents reviewed for care plans. Vision care plan was not	F 0657	F - 657 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the care plan of	04/12/2024

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	revised. Droplet isolation care plan was not removed, and short term stay care plan was not removed. Catheter care plan was not revised or removed, and wound care plans were not revised. (Resident E, Resident F, Resident 13, Resident C) Findings include: 1. On 3/8/24 at 9:40 A.M., Resident E was observed eating breakfast in her room and did not have glasses on. On 3/11/24 at 9:10 A.M., Resident E was observed sitting in her wheelchair in her room not wearing glasses. On 3/6/24 at 10:58 A.M., Resident E's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, dysphagia, stroke, right side hemiplegia (paralysis of one side of the body). The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 2/16/24 indicated Resident E's cognition was moderately impaired, was totally dependent on 2 staff for bed mobility, transfers, toileting and extensive assist of 1 staff for eating. A current "[resident name] wears glasses" Vision Care Plan, dated 8/17/23, included, but was not limited to the following interventions: "Ensure Resident E is wearing glasses which are clean, free from scratches, and in good repair", initiated 8/17/23 During an interview on 3/11/24 at 9:12 A.M., Registered Nurse (RN) 9 indicated she didn't think Resident E had glasses.		the resident identified as resident E has now been updated to reflect the resident's current visual status. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the care plan of the resident identified as resident 13 has been revised and the isolation care plan has now been removed. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the care plan of the resident identified as resident F has been revised and the short-term stay care plan has now been removed. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident C no longer resides at the facility. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all care plans has been conducted to ensure all care plans are currently accurate and reflect each resident's current condition/status/issues. *The measures that have been put into place to ensure that the*	

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	155508	A. BUILDING 00 B. WING	03/14/2024

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	During an interview on 3/12/24 at 1:28 P.M., the MDS Coordinator indicated she was not sure if the resident wore glasses but she would check into it. During an interview on 3/13/24 at 10:13 A.M., the MDS Coordinator indicated Resident E doesn't have glasses and she was unsure why there was a care plan for them. During an interview on 3/13/24 at 9:44 A.M., the Assistant Director of Nursing (ADON) indicated the resident care plans should be revised and they should be completed by the next day during the morning meeting or Monday morning if something changed over the weekend. Social Services and the MDS Coordinator are responsible for revising care plans. 2. On 3/4/24 at 8:32 A.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, hypertension and diabetes mellitus. The most recent quarterly MDS, dated 1/27/24, indicated Resident 13 was cognitively intact. Discontinued Physician's Orders included, but were not limited to, "...Droplet Precautions x 7 days for positive influenza test....start date 1/20/2024...end date 1/26/2024. Current care plans included, but were not limited to, "I am in contact/droplet isolation as I am positive for Influenza..." dated 1/25/24. During an interview on 3/8/24 at 9:09 A.M., the DON (Director of Nursing) indicated the MDS Coordinator revised care plans. During an interview on 3/11/24 at 1:53 P.M., the MDS Coordinator indicated the isolation care plan		*deficient practice does not recur is that* a mandatory in-service has been provided for all members of the interdisciplinary team on the facility's care planning policy. Each member was re-educated on their responsibility to ensure that the resident's care plans are current and accurate to reflect the needs of each individual resident. It is also each members responsibility to ensure that the resident's care plans are being followed by all applicable staff members. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the resident's care plans to ensure that the care plan accurately reflects the resident's current needs. The tool will also monitor to ensure that all respective staff members are following each resident's care plan interventions as outlined in their individualized plan of care. This tool will be completed by the MDS Coordinator and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	should have been removed 7 days after Resident 13 was diagnosed with influenza. 3. On 3/5/24 at 1:01 P.M., Resident F's clinical record was reviewed. Diagnoses included, but were not limited to, seizure disorder, anxiety disorder, and heart failure. The most recent Quarterly MDS, dated 1/29/24, indicated Resident F had moderate cognitive impairment. Current care plans included, but were not limited to, "[name of resident] plans to be here short-term.." revised 2/7/23 and, "[name of Resident anticipates Long Term Care; as she is unable to provide her own personal care, administer own medications, do meal preparation, grocery shop, or pay bills independently and have no one who can assist her in meeting her daily needs around the clock..." dated 1/30/24 During an interview on 3/11/24 at 1:45 P.M., the MDS Coordinator indicated that the short term care plan should not have been in the clinical record. 4. On 3/05/24 at 1:56 P.M., Resident C's clinical record was reviewed. He was admitted on 10/10/23. Diagnosis included, but were not limited to diabetes mellitus with diabetic polyneuropathy, open wound left foot, and multiple myeloma in remission. The most current State optional, Quarterly MDS (Minimum Data Set) Assessment, dated 2/11/24, indicated cognition status was not completed. Resident C required total dependence of two assistants for bed mobility, transfers, and toilet use and extensive assistance of one for eating. Skin assessment indicated Resident C had one or more unhealed pressure ulcers, one Stage 3 pressure ulcer, four unstagable pressure ulcers			

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	presenting as deep tissue injury, one venous and arterial ulcer present, diabetic foot ulcer, open lesion on the foot, surgical wound, and moisture associated skin damage. Resident C was receiving nutrition or hydration intervention to manage skin problems, pressure ulcer care, surgical wound care, application of nonsurgical dressings to areas other than to feet, application of ointments/medications other than to feet, and application of dressings to feet. Current physician orders included, but were not limited to the following: Santyl Ointment 250 UNIT/GM (gram) Apply to Wound Sites topically every day shift for wound care, dated 3/2/2024 Triad Hydrophilic Wound Dress External Paste (Wound Dressings) Apply to buttocks topically every shift for excoration, dated 3/1/2024 Monitor Dressing - Left Calf (2 areas: Proximal and distal): Ensure dressing is clean, dry, and intact. If soiled or dislodged, change per PRN (as needed) orders every night shift, dated 3/1/2024 Dressing Change - Left Calf (2 areas: proximal and distal): Cleanse with wound cleanser, pat dry. Apply Santyl to wound bed. Cover with bordered gauze dressing. Initial and date, every day shift for Wound Care and as needed for soiled or dislodged dressing, dated 3/1/2024 Monitor Dressing - Left JP (Jackson-Pratt) Drain Removal Site: Ensure dressing is clean, dry, and intact. If soiled or dislodged, change per PRN orders, every night shift, dated 3/1/2024 Dressing Change - Left JP Removal Site: Cleanse with wound cleanser, pat dry. Pack with calcium			

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	alginate. Cover with bordered gauze dressing. Initial and date. every day shift for Wound Care AND as needed for soiled or dislodged dressing, dated 3/1/2024 Monitor Dressing - RLE (Right Lower Extremity) (3 areas: anterior shin, medial RLE posterior and distal): Ensure dressing is clean, dry, and intact. If soiled or dislodged, change per PRN orders, every night shift, dated 3/1/2024 Dressing Change - RLE (3 areas: anterior shin, medial RLE posterior and distal): Cleanse with wound cleanser, pat dry. Apply Santyl to wound bed. Cover with bordered gauze dressing. Initial and date. every day shift for Wound Care AND as needed for soiled or dislodged dressing, dated 3/1/2024 Dressing Change - Abdomen (If vac (vacuum) becomes displaced, and unable to be reapplied): Cleanse with wound cleanser, pat dry. Apply adaptic to graft. Back with Kerlix moistened with NaCl (sodium chloride). Cover with foam dressing, secure with Kerlix and tape. Notify MD (Medical Doctor) and Wound Nurse ASAP (as soon as possible), as needed, dated 3/1/2024 Monitor Dressing - Abdomen: Ensure Vac is on and functioning at 125 continuous. If Vac becomes dislodged may change per PRN orders, every shift, dated 3/1/2024 Dressing Change - Abdomen: Remove Wound Vac. Cleanse with wound cleanser, pat dry. Apply barrier layer around wound. Pack with black foam. Secure with vac dressing. Apply vac at 125 Continuous. every day shift every Mon, Wed, Fri for Wound care AND as needed for Dislodged vac, dated 3/1/2024			

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	Monitor Dressing - Lateral Right foot at 5th MT (Metataursal) Joint: Ensure dressing is clean, dry, and intact. If soiled or dislodged, change per PRN orders, every night shift, dated 3/1/2024 Dressing Change - Lateral Right foot at 5th MT Joint: Cleanse with wound cleanser, pat dry. Apply Santyl to wound bed. Cover with bordered gauze dressing. Initial and date, every day shift for Wound Care AND as needed for soiled or dislodged dressing, dated 3/1/2024 Dressing Change - Left Heel (If vac becomes displaced, and unable to be reapplied): Cleanse with wound cleanser, pat dry. Apply adaptic to graft. Back with Kerlix moistened with NaCl. Cover with foam dressing, secure with Kerlix and tape. Notify MD and Wound Nurse ASAP. as needed for dislodged vac, dated 3/1/2024 Monitor Dressing - Left Heel: Ensure Vac is on and functioning at 125 continuous. If Vac becomes dislodged may change per PRN orders, every shift for wound vac, dated 3/1/2024 Dressing Change - Left Heel: Remove Wound Vac. Cleanse with wound cleanser, pat dry. Apply barrier layer around wound and to bridge site. Apply adaptic to graft. Cover with black foam, bridged to top of foot. Secure with vac dressing. Apply vac at 125 Continuous, every day shift every Mon, Wed, Fri for Wound Care AND as needed for If vac becomes dislodged, dated 2/28/2024 Current Care Plans included, but were not limited to the following: Resident C has an Indwelling Catheter: Neurogenic bladder, Skin Breakdown, dated			

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	11/14/2023 Resident does not have a Foley catheter. The resident has actual impairment to skin integrity of the Left Heel and Right Lateral Foot r/t (related to) suspected deep tissue injury, dated 12/6/2023 The interventions included the following which were all dated 12/6/23: Educate resident/family/caregivers of causative factors and measures to prevent skin injury. · Encourage good nutrition and hydration in order to promote healthier skin. · Follow facility protocols for treatment of injury. · Identify/document potential causative factors and eliminate/resolve where possible. · Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD. · Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. · Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. The resident has diabetic ulcer of the Left Great Toe r/t Diabetes, dated 12/6/2023 The interventions included the following which were all dated 12/6/23: Carefully dry between toes but do not apply lotion between toes. Determine and treat cause: poor fitting shoes, poor blood sugar control, pressure area, infection.			

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	· Ensure appropriate protective devices are applied to affected areas. · Monitor Blood Sugar Levels. · Monitor/document wound: Size, Depth, Margins: periwound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene, Document progress in wound healing on an ongoing basis. Notify MD as indicated. · Monitor/document/report PRN any s/sx of infection: Green drainage, Foul odor, Redness and swelling, Red lines coming from the wound, Excessive pain, Fever. · Monitor/document/report PRN changes in wound color, temp, sensation, pain, or presence of drainage and odor. · Position resident off affected area. Change position every 2 hours and PRN. During an interview on 3/13/24 at 9:43 A.M., ADON (Assistant Director of Nursing) indicated care plans should be updated when a resident returns from the hospital and a Foley catheter has been removed and multiple surgeries have been done with wound vacuums in place. On 3/11/24 at 10:55 A.M., the Administrator provided an undated Care Plans, Comprehensive Person-Centered Policy that indicated, "...11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change..." 3.1-35(d)(2) 3.1-35(d)(2)(B) 3.1-35(e)			
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities.			

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	§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 and interview, the facility failed to ensure an ongoing activity program was in place for residents in 2 of 2 halls during the survey period. (West Hall and East Hall) Findings included: During an observation on 3/4/24 at 12:10 P.M., the activity calendar posted by the main dining room was for February 2024. During an observation on 3/4/24 at 12:22 P.M., Resident E had a February 2024 activities calendar hanging in her room. During a continuous observation on 3/7/24 from 10:20 A.M. to 10:35 A.M., 6 residents were seated in the dining room, 3 of them talking to each other, the others were seated alone. 3 residents were sitting in the living room area watching tv. According to the activity schedule, at 10:30 A.M., there should have been a "Lucky Numbers" activity. During an interview on 3/4/24 at 12:22 P.M., Resident 30 indicated he was bored most of the time because there were not enough activities. He indicated he would like to go outside the facility to other places and he indicated he did not know	F 0679	F - 679 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the facility is in the process of hiring a new activities director. The residents identified as resident E, 30 and 203 will be provided with activities that meet their activities interest with the support of the new activity's director. A designated bus driver will now be responsible for transporting residents to and from appointments so that the activity director can focus fully on providing activities for the residents. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. The facility is in the process of hiring a new activities director who will be responsible for providing activities of interests to all residents. A designated bus driver	04/12/2024

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	what activities were going on that day. During an interview on 3/5/24 at 1:37 P.M., Occupational Therapy Assistant 1 indicated Resident 203 came down to the therapy area because it gave her something to do. She indicated Resident 203 felt better when she got out of bed because otherwise she just laid there all day. She wasn't sure what the resident did at times when therapy employees were not there. During the resident council meeting on 3/6/24 at 10:00 A.M., several residents indicated there were not enough activities, if any, throughout the day for months. At that time, they indicated they sat in the dining room watching tv, talking to each other, or in their rooms. During an interview on 3/11/24 at 9:12 A.M., Registered Nurse (RN) 9 indicated they did have an Activities Director that was in charge of having activities but she was busy taking residents to their appointments all the time and not able to hold activities. On that day, she indicated she had 6 appointments scheduled. The Activities Assistant would sometimes help but at some point a while back she transferred into dietary so there was no activities assistant. She indicated it'd probably been 6 months since their Activities director was available. During an interview on 3/11/24 at 9:20 A.M., Occupational Therapist 4 indicated some residents come down and use the therapy equipment if they aren't using it at the time for therapy and hang out in therapy area so they have something to do. During an interview on 3/12/24 at 1:53 P.M., the Administrator indicated the Activities Director's		will now be responsible for transporting residents to and from appointments so that the activity director can focus fully on providing activities for the residents. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service will be provided for the new activity director on their responsibilities for providing activities of individualized interest for each resident. This in-service will be in addition to their job specific orientation to the facility. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool will be developed and implemented to monitor the facility's activity program to ensure that the program meets in the individualized interest needs of the residents. The tool will also monitor to ensure that activities are provided as scheduled on the activities calendar. This tool will be completed by the Social Services Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	hours vary with resident's transportation to appointments. They have an Activities Assistant job posted. She indicated there should be an activities program provided for the residents every day and their activities were not really happening because the facility's usual bus driver went down south for the winter so he wouldn't be back until the end of March 2024. At that time, the Activities Director would then be available to do activities. On 3/13/24 at 8:50 A.M., a current Activity Program Policy, dated 5/24/23, was provided by the Administrator and indicated "Activity programs designed to meet the needs of each resident are available on a daily basis ... Activities are scheduled 7(seven) days a week ... " 3.1-33(a)			
F 0684 SS=D 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 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 do a comprehensive assessment of residents and that residents received appropriate treatment and care in accordance with professional standards of practice for 3 of 9 residents reviewed for hospitalizations. A resident's weight and height were not accurately assessed, a resident's skin	F 0684	F - 684 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident E has now been reassessed by nursing and dietary. Accurate height and	04/12/2024

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	assessments were not completed, and a resident was not given Lasix (diuretic) as ordered and was hospitalized for weight gain. (Resident E, Resident 3, Resident G) Findings include: 1. On 3/6/24 at 10:58 A.M., Resident E's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, dysphagia, stroke, right side hemiplegia (paralysis of one side of the body). The most recent Quarterly MDS Assessment, dated 2/16/24, indicated Resident E's cognition was moderately impaired, was totally dependent on 2 staff for bed mobility, transfers, toileting, and an extensive assist of 1 staff for eating and no weight gain. Physician's Orders included, but were not limited to, the following: daily weight for 3 days, ordered 3/5/24 ending on 3/8/24 weekly weights for 4 weeks, ordered 3/5/24 to start 3/11/24 double meat portions three times a day, ordered 3/5/24 house supplement, 120 cubic centimeters (cc) one time a day, ordered 3/5/24 A current Nutrition Care Plan, dated 9/8/23, included, but was not limited to, the following intervention: Assist the resident with developing a support system to aid in weight loss efforts, including friends, family, other residents, volunteers, etc.,		weights have been documented in the clinical record and the physician has been updated on the resident's condition. Interventions have been put in place to address the resident's current needs and the care plan has been updated. The MDS has also been updated to reflect the resident's current conditions/status. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the nurse practitioner did thoroughly examine the resident identified as resident 3 on 12-28-23 and the findings are documented in the clinical record. The resident identified as resident 3 has been reassessed by the nurse. The physician has been notified of the resident's current condition and appropriate interventions are in place. Resident 3 is now receiving all medications, treatments and services to meet the resident's current needs. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident G has now had a new skin assessment completed and documented in the clinical record. The physician has been updated on the resident's skin condition. Appropriate treatment orders are now in place	

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	155508	A. BUILDING 00 B. WING	03/14/2024

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	initiated 9/8/23 Resident E's weights listed in the resident's clinical record were reviewed and listed below: 8/17/23 151.2 lbs (pounds) (wheelchair) 9/11/23 151.3 lbs (wheelchair) 9/14/23 151.6 lbs (wheelchair) 10/3/23 153 lbs (wheelchair) 11/7/23 156.8 lbs (wheelchair) 12/17/23 156.9 lbs (wheelchair) 1/17/24 160 lbs (wheelchair) 1/17/24 201 lbs (wheelchair), was documented as incorrect 1/26/24 161 lbs (standing) 2/1/24 161 lbs (standing) 2/9/24 210 lbs (wheelchair), weight gain of 50 lbs (30.43% increase) 2/17/24 210 lbs (wheelchair) 3/1/24 199.8 lbs (wheelchair), weight loss of 10.2 lbs (4.86% loss) Resident E's heights listed in the resident's clinical record were reviewed and listed below: 8/17/23 67 inches (laying down) 2/9/24 55 inches (standing), height loss of 12 inches On 2/9/24 at 2:45 P.M., a Clinical Admission note indicated the 2/9/24 weight of 210 lb and 2/9/24 height of 55 inches with no mention of assessment or that this was a significant change for the resident. On 3/4/24 at 2:47 P.M., a weight change note created by the Registered Dietician (RD) indicated Resident E had a weight change. "Intake is good. Likes vending machine. Skin issues followed by wound nurse. Aspiration risk sent to guardian to sign. Will suggest adding double protein at meals, add [name of shake] Q [every] day. NP aware. Will		in accordance with the physician's orders and the plan of care. Weekly assessments of the skin condition are now being documented in accordance with facility policy and the physician will be notified of any significant changes. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide review of all resident assessments have now been conducted to ensure that all of the resident's conditions/issues have been identified, physician notified and appropriate interventions have been put in place to address all identified conditions and issues. All resident's conditions will be assessed and findings documented in accordance with facility policy and each resident's individualized plan of care. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses and QMAs on the facility's policy related to resident comprehensive assessments. The nurses have been re-educated on their responsibilities related to assessing the residents, documenting the findings, reporting to the physician's and	

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	monitor weekly. RD avail. as needed." Resident E's progress notes lacked an assessment, reweigh, and notification to the representative, physician or Nurse Practitioner (NP) after the significant weight gain of 50 lbs in 8 days documented on 2/9/24. Resident E's progress notes lacked an assessment, height retaken, and notification to the representative, physician or NP after the significant height change of 12 inches in 5 months, 23 days documented on 2/9/24. Recent hospital records were reviewed and indicated Resident E's weight was 210.0 lbs on 1/22/24. No height was listed. Resident E's weight was 210.0 lbs and height was 65 inches on 2/6/24. During an interview on 3/8/24 at 9:38 A.M., Licensed Practical Nurse (LPN)14 indicated a resident with a weight change like that should raise flags because it is definitely significant. Staff should have reweighed the resident, notified family, NP, Director of Nursing (DON), assessed for edema or other causes of weight gain, and all of that should have been documented in the resident's progress notes. During an interview on 3/12/24 at 1:35 P.M., the ADON indicated weights were different because people were weighing wheelchairs differently. In the beginning of February 2024, they re-educated staff and decided to have 1 staff weigh each resident. The weight listed was a significant change and assessments should have been done, reweighed, and the NP should have been notified. As far as the height, it says standing and she can't stand so that's not correct.		providing the necessary care and services to meet the resident's needs based on the resident assessments. F – 684 (continued) *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the documentation of comprehensive assessments in accordance with facility policy and the resident's needs. The tool will monitor to ensure that appropriate assessments are being completed per facility policy and as warranted based on the resident's current condition/needs. The tool will also monitor to ensure that the physician is notified of the results of the assessments and to ensure appropriate interventions are provided to meet those resident needs. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	During an interview on 3/12/24 at 1:28 P.M., the MDS Coordinator indicated when Resident E went to the hospital and came back on 2/9/24 she was in a new wheelchair so the weight was probably effected and there should be a note indicating that. She was not sure if the weight gain should have been indicated on the 2/26/24 MDS Assessment. During an interview on 3/13/24 at 9:34 A.M., the ADON indicated the height was wrong and redone that morning by herself and she indicated 68 inches was the correct height and her clinical record was updated. At that time, Clinical Support indicated weights were an ongoing issue they discovered and reweighed everyone and their wheelchairs the first part of February 2024 so the 201 lbs that is crossed out on 1/26/24 was probably right and weights from there were probably accurate. During an interview on 3/13/24 at 9:44 A.M., the ADON indicated the Nutrition Care Plan should have been revised the next day during morning meeting or Monday morning if it was a weekend. During an interview on 3/13/24 at 10:22 A.M., the MDS Coordinator indicated she reviewed the hospital reports that say she weighed 210 lbs. She had never weighed 210 lbs here. She didn't know where the hospital got the 210 lbs weight and that's why the MDS Assessment indicated no weight gain. During an interview on 3/13/24 at 10:24 A.M., the ADON indicated she was not sure what happened with Resident E's weights. She went to Resident E's room to look at her wheelchair and it is the same wheelchair she had always had.			

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	On 3/14/24 at 9:41 A.M., LPN 21 was observed weighing Resident E. She zeroed out the scale and pulled Resident E onto the scale in her wheelchair without the foot pedals or cushion in it. The scale indicated her weight was 226.8 lbs. Then she weighed the wheelchair as it was without the resident in it and it weighed 40.4 lbs. She thought all wheelchairs were weighed and weights wrote on them but there was no weight on hers. That's why she weighed it again and put the amount on the chair so they don't have to weigh it every time. LPN 21 entered the weight of the resident as 186.0 lbs in the clinical record which was a loss of 13.8 lbs in 13 days. She indicated that was a significant weight loss and she would notify the NP and ADON. 2. On 3/7/24 at 8:44 A.M., Resident 3's clinical record was reviewed. Diagnosis included, but were not limited to, heart failure, cardiomyopathy, and depression. The most recent Annual MDS (Minimum Data Set) Assessment, dated 2/18/24, indicated no cognitive impairment. Physician orders included, but were not limited to: Daily weights - call NP (Nurse Practitioner) when clinically indicated, dated 2/1/24. Historical physician orders included, but were not limited to: Regular diet, regular texture, regular consistency, dated 2/10/23. Daily weight for 7 days, dated 12/27/23. Daily weight, dated 1/23/24 through 1/31/24. Lasix Oral Tablet 20mg (milligram) (a diuretic) Give 1 tablet by mouth one time a day, dated 1/22/24. Lasix Oral Tablet 40mg Give 1 tablet by mouth			

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	every 24 hours as needed,dated 2/10/23. Spironolactone Oral Tablet 25mg (a diuretic) Give 12.5 mg by mouth one time a day, dated 5/4/23. A current nutrition care plan indicated to notify MD of any concerns, dated 3/22/23. Weights from 12/24/23 through 1/9/24 included the following: 12/25/23 229.8 pounds 12/27/23 229 pounds 12/29/23 230.5 pounds 12/30/23 231 pounds 12/31/23 230.5 pounds 1/2/24 231 pounds 1/3/24 234.8 pounds 1/9/24 231 pounds Progress notes included, but were not limited to, the following: 12/25/23 at 2:48 P.M. "Nurse called to resident's room this morning while CNA [Certified Nurse Aide] providing am care. Resident's abdomen appears much larger than normal. Resident currently laying on her back completely flat. Has abdominal hernia which is chronic. Abdomen is not distended but it is very wide; abdomen soft and non tender on palpation. Bowel sounds x4 present with last bm on 12/24. Denies any dyspnea while laying flat at this time. No nausea or early satiety reported. Will monitor for other symptoms" 12/26/23 at 10:45 A.M. "Resident has had an 18.8lb weight gain in the past month with no change in po [by mouth] intake. Resident has medical diagnosis of chf [chronic heart failure] and cardiomyopathy. Abdomen noted to be much larger in size. Resident roommate reported resident			

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	wheezing sometimes at night howeverresident [sic] always denies dyspnea. Will notify MD/NP" 12/26/23 at 10:50 A.M. "Notified NP of weight gain and increase in abdomen size. Order obtained to administer x1 lasix 40mg po and NP to see resident later on today" The clinical record lacked an order for lasix x1 40mg po as ordered by the Nurse Practitioner on 12/26/23. The clinical record lacked information related to Nurse Practitioner visit on 12/26/23. 1/6/24 at 4:03 P.M. "Family in facility, requesting Resident be sent out for weight gain, Resident assessed no wheezes, ABD [abdomen] is bigger in size however soft non tender, BS [bowel sounds] all 4 quads. Spoke with NP and she gave orders for medication changes and Family became persistant [sic] that Resident be sent for further eval [evaluation]. Resident will be prepped and sent to [hospital]" 1/6/24 at 9:50 P.M. "Resident admitted. Plan of care is IV [intravenous] lasix for excess fluid and a hernia consult. Resident's sister also reports that resident had a large amount of fecal material in her colon. Resident reported to be doing better" 1/19/24 at 3:54 P.M. "Resident returned from [hospital] today ... 1800 ml fluid restriction and cardiac 2 gm [gram] sodium diet per hospital dc [discharge] orders ..." 1/26/24 at 9:51 P.M. "Resident's current weight is 214.7lbs. Weight on 1/3/24 was 234.8lbs ... At hospital, resident was given lasix iv which Resident's family do brink [sic] her snacks to her			

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	room however she eats them in moderation. Resident has had medications in regards to her edema/swelling issues et will continue to monitor weight weekly" On 3/13/24 at 11:05 A.M., the MDS Coordinator indicated when a resident returned from the hospital, any diet order changes should be sent by the floor nurse to the doctor for clarification, then entered into the resident's orders. She indicated she did not know what had happened with Resident 3's diet order after returning from the hospital on 1/19/24, but was unsure if the diet ordered was offered by the facility. She indicated the order should have been clarified and a note made. On 3/13/24 at 1:42 P.M., the Assistant Director of Nursing (ADON) indicated Resident 3's order for lasix 40mg x1 made on 12/26/23 as well as the 1800ml (milliliter) fluid restriction could not be located and was probably missed in error. On 3/14/24 at 8:08 A.M., the ADON indicated the lasix 40mg x1 order from 12/26/23 had not been given per the order. She indicated the 1800ml fluid restriction that was ordered at the hospital had only been communicated to the facility via phone and that was why it was entered into the progress notes, and had not been part of the resident's written discharge orders. 3. On 3/4/24 at 10:44 A.M., Resident G was observed in bed with a laceration on her forehead. The area was red and scabbed. At that time, Resident G indicated the area had come form her sister's cat, but was unable to indicate when it happened or how long the area had been there. On 3/5/24 at 1:50 P.M., Resident G's clinical record			

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	was reviewed. Diagnosis included, but were not limited to, epilepsy. The most recent MDS Assessment, dated 2/6/24, indicated no cognitive impairment, no behaviors, and no open lesions or skin tears. On 3/7/24 at 9:00 A.M., Qualified Medication Aide (QMA) 27 indicated Resident G had been admitted with the area on her forehead almost a year ago, and it did not heal because she picked at it. A current potential for impairment to skin integrity care plan indicated to monitor/document location, size and treatment of skin injury, and to report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc, dated 6/2/23. A clinical admission assessment, dated 6/2/23, indicated no skin issues. Resident G's clinical record lacked progress notes about the area on her forehead. Resident G's clinical record lacked skin assessments related to the area on her forehead. Skin assessments were requested on 3/7/24 at 2:00 P.M. and not provided. No progress notes about the area on the forehead On 3/8/24 at 1:44 P.M., the Director of Nursing (DON) indicated Resident G had been admitted with the skin area on her forehead, and would often mess with it. She was unsure if it had gotten worse, but would check for any assessments for it. None were provided. On 3/12/24 at 9:03 A.M., the ADON indicated the area on Resident G's forehead should have been assessed, and staff should have added that			

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	information in a skin assessment. She indicated the information should have been on the clinical admission paperwork as well. On 3/13/24 at 12:48 P.M., a current Admission/Readmission Nursing Assessment policy, dated 1/1/19, was provided and indicated "Upon admission or readmission to the facility the admitting nurse will complete the electronic nursing assessment ... The sections which are to be completed are ... Skin Integrity ... Be sure under the skin integrity section to include any and all skin issues identified upon admission/readmission. If there is no skin integrity issues make note of that in the comments section under skin integrity" On 3/13/24 at 12:50 P.M., a current nondated Weight Assessment and Intervention Policy was provided by the ADON and indicated "Resident weights are monitored for undesirable or unintended weight loss or gain ... Any weight change of 5% [percent] or more since the last weight assessment is retaken the next day for confirmation ... " 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were			

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	unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure a resident with a pressure ulcer received necessary treatment and services to promote healing in 1 of 2 residents reviewed for pressure ulcers. A resident's wound culture was not collected timely, the wound vac (wound therapy using vacuum assisted closure) was not documented as physician ordered, and the wound was left open to air. (Resident E) Finding includes: 1. During an observation on 3/13/24 at 1:35 P.M., the Wound Nurse was going to change Resident E's pressure wound dressing on her right buttock. When the wound nurse pulled resident's pants and brief down, the wound did not have a dressing on it, was open to air, and the brief was saturated. On 3/6/24 at 10:58 A.M., Resident E's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, dysphagia, stroke, right side hemiplegia (paralysis of one side of the body). The most recent Quarterly MDS Assessment, dated 2/16/24, indicated Resident E's cognition was moderately impaired, was totally dependent on 2 staff for bed mobility, transfers, toileting, and an extensive assist of 1 staff for eating, and had a stage III pressure ulcer. Physician's Orders included, but were not limited	F 0686	F - 686 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident E now has the appropriate orders in place for the treatment of their pressure wound. The wound treatment is being provided in accordance with the physician's orders. Wound cultures are being obtained timely in accordance with the physician's orders. The most recent assessment of the pressure ulcer indicates that the wound is continuing to heal. The resident's care plan has been updated to reflect the resident's current skin condition. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. All residents skin conditions have been re-assessed to ensure all appropriate preventative and treatment orders are in place to address each resident's current skin needs. *The measures that have been put into place to ensure that the*	04/12/2024

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	to, the following: Change dressing to right buttock: cleanse with wound cleanser, pat dry. Apply Santyl (medication used for removing damaged skin to allow for wound healing) to wound bed. Pack with calcium alginate (absorbs fluid from wounds). Cover with 6 x 6 bordered gauze dressing. Initial and date. every day shift, ordered 2/14/24 and discontinued 3/13/24 change dressing to right buttock: cleanse with wound cleanser, pat dry. Apply Santyl to wound bed. Pack with Calcium alginate, cover with 6 x 6 bordered gauze dressing. Initial and date. As needed for soiled or dislodged dressing, ordered 2/14/24 and discontinued 3/13/24 change dressing to right buttock: cleanse with wound cleanser, pat dry. Pack with Kerlix (gauze)moistened with NaCl (sodium chloride) and cover with bordered gauze dressing as needed for soiled or dislodged dressing, ordered 3/13/24 change dressing to right buttock: cleanse with wound cleanser, pat dry. Pack with Kerlix moistened with NaCl and cover with bordered gauze dressing two times a day, ordered 3/13/24 monitor dressing right buttock: ensure dressing is clean, dry, and intact every night shift. If soiled or dislodged, changer per PRN (as needed) orders, ordered 3/13/24 wound culture to wound on right buttock, ordered 3/7/24 amoxicillin-pot clavulanate (antibiotic) 875-125 mg (milligram) tablet, give 1 tablet by mouth two times a day for bacterial infection for 7 days, ordered 3/10/24		*deficient practice does not recur is that* a mandatory in-service has been provided for all nursing staff on the facility's pressure ulcer prevention and treatment policies. All staff was re-educated on their responsibility to ensure that each resident's skin prevention and treatment plans are being followed in accordance with their respective treatment orders and the plan of care. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to ensure that each resident is receiving the necessary care and services in the prevention and/or treatment of pressure ulcers. This tool will monitor to ensure that each resident is having their skin condition assessed weekly and that all skin conditions including pressure ulcers are receiving the appropriate treatment in accordance with their plan of care. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	155508	A. BUILDING 00 B. WING	03/14/2024

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	The clinical record lacked an order for a wound vac. A current Skin Integrity Care plan, dated 9/8/23 included, but was not limited to, the following interventions: Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs and symptoms) of infection, maceration etc. to MD (Medical Doctor), initiated 9/8/23 The clinical record lacked a care plan specific to pressure ulcers. Progress notes included, but were not limited to, the following: On 2/18/24 at 9:53 A.M., "Alert Note: pt [patient] refusing dressing to buttocks at this time stating "I'm leaving for church now" pt loa [leave of absence] at this time to church with friend." On 3/5/24 at 12:07 P.M., "Skin/Wound note: ED [Executive Director] notified wound nurse of concerns that wound is worsening. Will assess and re-evaluate tx [treatment] plan during 3/6 wound rounds." On 3/7/24 at 10:53 A.M., "Communication with physician note: Notified [Doctor's Name] and [Nurse Practitioner name] of increased depth to wound bed. Requested wound vac. [Doctor's Name] agreed to wound vac, ordered wound culture. Recommended protein supplements and diet modification geared toward higher protein intake. Informed him of double meat portion and house supplement daily per dietician. MD agreed to plan of care."			

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	On 3/11/24 at 5:22 P.M., "Doctor Visit: [Doctor's Name] in facility. Resident was seen by MD. MD reviewed labs, vitals, and medications. MD assessed resident's sacral wound [sic]. MD will be discussing wound with WC [wound care] RN [Registered Nurse]. No changes at current to plan of care. On 3/12/24 at 5:00 P.M., "Communication with physician note: Wound culture results reviewed by MD et [and] no changes to current antibiotic given at this time." On 3/13/24 at 12:15 P.M., "Skin/Wound note: Representative from [company name] called to notify that delivery driver is unable to make it to facility today. Vac will be sent overnight." On 3/13/24 at 1:00 P.M., "Communication with physician note: MD notified of delay in delivery of wound vac. Informed him that vac will be sent overnight delivery. Order's [sic] rec'd [received] to pack with Kerlix moistened with NACl and cover with bordered gauze dressing BID [twice daily] until vac rec'd." On 3/13/24 at 1:30 P.M., "Skin/wound note: Dressing change completed this date with State surveyor present. Originally plan of care was to place wound vac this date, but due to delay in receipt of vac order's were placed for wet to dry dressing, which was performed during this dressing change. Wound was found to be open to air upon initial assessment of wound bed ... " A Buttock wound culture was ordered on 3/7/24 at 10:53 A.M., collected at the facility on 3/9/24 at 3:29 P.M., received to lab on 3/9/24 at 11:55 P.M., reported to the facility on 3/12/24 at 8:00 A.M., and reported to the MD on 3/13/24 at 4:47 P.M. It			

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	was reviewed and indicated "... mixed gastrointestinal flora present ... " Weekly Pressure Wound Notes included the following: 1/23/24-First observation of the acquired stage III pressure wound on right buttock. The length was 5 cm (centimeters), width 5 cm, and depth 0.1 cm. Treatment included: Cleanse with wound cleanser, pat dry. Apply Anasept gel (antimicrobial) to wound bed. Cover with bordered gauze dressing. Initial and date. Change daily and PRN. 1/31/24-The observation of the acquired stage III pressure wound on right buttock indicated the pressure wound was improving. The length was 5 cm, width 4.5 cm, and depth 0.1 cm. Treatment included: Cleanse with wound cleanser, pat dry. Apply Santyl to wound bed. Cover with bordered gauze dressing. Initial and date. Change daily and PRN. 2/9/24-The resident returned from a 4 day hospital stay and the first observation of the stage III pressure wound on right buttock the resident admitted with indicated the length was 5.4 cm, width 4.8 cm, and depth 0.1 cm. Treatment included: Cleanse with wound cleanser, pat dry. Apply Santyl to wound bed. Cover with bordered gauze dressing. Initial and date. Change daily and PRN. 2/14/24-The observation of the stage III pressure wound on right buttock the resident admitted back with on 2/9/24 indicated the length was 5 cm, width 5 cm, and depth 2 cm. "The wound was significantly debrided at hospital." Treatment included: Cleanse with wound cleanser, pat dry. Apply Santyl to wound bed. Pack with calcium alginate. Cover with bordered gauze dressing.			

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	Initial and date. Change daily and PRN. 2/21/24-The observation of the stage III pressure wound on right buttock the resident admitted back with on 2/9/24 indicated the length was 5.5 cm, width 5.5 cm, and depth 3 cm and worsening. "Unable to determine at this time due to thick slough." Treatment included: Cleanse with wound cleanser, pat dry. Apply Santyl to wound bed. Pack with calcium alginate. Cover with bordered gauze dressing. Initial and date. Change daily and PRN. 2/28/24-The observation of the stage III pressure wound on right buttock the resident admitted back with on 2/9/24 indicated the length was 5 cm, width 4.5 cm, and depth 2.8 cm with approximately 1 cm in from edges of circumference of wound area 0.1 depth of granulation tissue. 2 cm by 2 cm circular area in the middle has a depth of 2.8 cm at the deepest and 2.3 cm at remaining. Wound was improving. Treatment included: Cleanse with wound cleanser, pat dry. Apply Santyl to wound bed. Pack with calcium alginate. Cover with bordered gauze dressing. Initial and date. Change daily and PRN. 3/6/24-The observation of the stage III pressure wound on right buttock the resident admitted back with on 2/9/24 indicated the length was 3 cm, width 3.8 cm, and depth 3.8 cm. Odor present. Undermining believed to be 4.3 cm from 2-5 o'clock. Wound was worsening. Treatment included: Cleanse with wound cleanser, pat dry. Apply Santyl to wound bed. Pack with calcium alginate. Cover with bordered gauze dressing. Initial and date. Change daily and PRN. 3/13/24-The observation of the stage III pressure wound on right buttock the resident admitted			

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	back with on 2/9/24 indicated the length was 2.5 cm, width 2.1 cm, and depth 4.1 cm. Wound appears to be cone shaped with 3.6 cm being the deepest layer. The wound was improving. Treatment included: Cleanse with wound cleanser, pat dry. Apply Santyl to wound bed. Pack with calcium alginate. Cover with bordered gauze dressing. Initial and date. Change daily and PRN. Wound vac to arrive tomorrow. On 3/13/24 at 2:05 P.M., Resident E's Treatment Administration Record (TAR) for March 2024 was reviewed and indicated Licensed Practical Nurse (LPN) 5 had changed the dressing on the resident's right buttock. During an interview on 3/12/24 at 12:03 P.M., the Assistant Director of Nursing (ADON) indicated the right buttock wound was not new but the wound worsened between when resident was admitted to the hospital on 2/5/24 and returned 2/9/24. During an interview on 3/13/24 at 1:51 P.M., the Wound Nurse indicated the wound was to have a dressing on it and was not supposed to be open to air. If it was not on during incontinence care, the nurse or I should have been notified. She indicated the wound being open to air for less then 24 hours should not affect the wound, but getting bowel movement in the wound could. Day shift should make sure it gets changed and night shift should check the dressing to make sure it was still dry, intact, and record on resident's TAR. The CNA that provided care should have alerted nurse there was no dressing. The wound vac should have been in physician's orders. During an interview on 3/13/24 at 1:55 P.M., Certified Nursing Aide (CNA) 3 said she changed			

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	Resident E last today at 10:00 A.M., and there wasn't a dressing on the wound at that time. When she provided incontinence care yesterday at 3:00 P.M. before she left, it was there. During an interview on 3/13/24 at 1:57 P.M., LPN 5 indicated he marked the TAR for 3/13/24 that he changed the dressing, but he did not look at it or change it because it was Wednesday and he knew the Wound Nurse would change the dressing when she was here. On 3/14/24 at 8:00 A.M., a nondated current Pressure Ulcer Policy was requested and provided by the ADON and indicated " ...1. The physician will order pertinent wound treatments, including pressure reduction surgaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc. [etcetera], and application of topical agents..." 3.1-40(a)(1)			
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents for 4 of 7 residents reviewed for accidents. Interventions were not implemented	F 0689	F - 689 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident	04/12/2024

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	following falls, thorough assessments were not performed following unwitnessed falls, and assessments were not completed for a residents with an electronic cigarette. (Resident 7, Resident 31, Resident G, West Hall Treatment Cart) Findings include: 1. On 3/5/24 at 10:49 A.M., Resident 7 was observed lying in bed using an electronic cigarette. On 3/7/24 at 8:48 A.M., Resident 7's clinical record was reviewed. Diagnosis included, but were not limited to, Alzheimer's disease, dementia, and depression. The most recent MDS (minimum data set) Assessment, dated 12/23/23, indicated no cognitive impairment and no behaviors. Resident 7's clinical record lacked an order related to the use of an electronic cigarette. Resident 7's clinical record lacked a care plan related to the use of an electronic cigarette. Resident 7's clinical record lacked an assessment related to the use of an electronic cigarette. On 3/7/24 at 9:08 A.M., Certified Nurse Aide (CNA) 3 indicated Resident 7 used to use an electronic cigarette, but did not use one currently. On 3/7/24 at 11:45 A.M., Resident 7 indicated she did use her electronic cigarette in her bed, as she did not get out of bed. She indicated her son used to bring her two a week, and now brought her one per week. She indicated when her roommate recently moved out, she took a couple puffs on her way out.		identified as resident 7 no longer smokes or utilizes an electronic cigarette. If resident 7 does decide to start smoking in the future an appropriate assessment will be completed and appropriate safety interventions put in place. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 31 has had their fall documentation reviewed. Resident 31's fall risk care plan has been updated to include appropriate interventions in an attempt to prevent future falls. Should resident 31 have any future falls, neuro checks will be completed and documented in the clinical record as warranted per facility policy and the care plan will be updated with additional new appropriate interventions. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident G has had their fall documentation reviewed. Resident G's fall risk care plan has been updated to include appropriate interventions in an attempt to prevent future falls. Should resident G have any future falls, neuro checks will be completed and documented in the clinical record as warranted per facility policy and the care plan will be updated with additional new	

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	On 3/12/24 at 10:14 A.M., The Assistant Director of Nursing (ADON) indicated staff should have been aware of which residents used electronic cigarettes. She indicated an electronic cigarette had been taken from Resident 7 the previous week, but no assessments had been completed at that time. She indicated there also should have been a progress note about the event. The ADON indicated there were currently no safeguards for residents with vapes or electronic cigarettes, as the staff was not aware of who actually had possession of them. As of 3/14/24 at 11:02 A.M., Resident 7's clinical record lacked documentation of an electronic cigarette being found or taken from her, assessments, or notification to the physician following the event. 2. On 3/4/24 at 9:29 A.M., Resident 31 was observed sitting in a wheelchair in her room. Bruising and swelling was observed to the left eye. On 3/6/24 at 11:29 A.M., Resident 31's clinical record was reviewed. Diagnosis included, but were not limited to, Bipolar disorder and dementia. The most recent MDS Assessment, dated 1/30/24, indicated no cognitive impairment, no behaviors, and no falls. Resident 31 required assistance of one staff with toileting. Resident 31's clinical record lacked current physician orders related to interventions to prevent falls. A current risk for falls care plan included the following interventions: assist to a seated position when observed to ambulate long distances, dated 8/26/21.		appropriate interventions. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* West Hall treatment cart is now locked at all times when not directly in use by the nurse/QMA. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by the deficient practice. All medication and treatment carts were checked and found to be securely locked when not in use. The fall documentation of all falls that have occurred within the past thirty days has been reviewed. The care plans of those residents with falls have also been reviewed and updated to reflect new appropriate safety interventions post each fall. Neuro checks have also been documented when warranted and scanned into the clinical record. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses and QMAs on the facility policies related to the facility's fall prevention program. The staff have also been re-educated on their responsibility to document neuro checks when warranted and to update the care plan with an	

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	assist to keep frequently traveled pathways in my room clutter free, dated 8/31/21. assist with activities of daily living routinely and as needed, dated 1/28/21. keep call light within reach and eye sight, dated 8/31/21. keep frequently used personal items within reach, dated 1/28/21. non skid footwear at all times, dated 1/28/21. non skid strips to floor exit side of the bed, dated 8/26/21. staff to remain with resident during toileting as she will allow, dated 3/4/24. staff to walk with me to and from dining room, dated 9/22/21. therapy as needed, dated 1/28/21. toilet upon rising, before bed, before and after activities and meals and as needed, dated 8/31/21. Resident 31 experienced the following falls from 11/1/23 through 3/2/24: Fall 1 11/1/23 at 6:30 A.M. Resident was found sitting on the floor beside the bed with swelling to the left orbital area. As the hematoma increased in size, an order was obtained to sent to the ER (emergency room) for evaluation. The fall was unwitnessed. The fall incident report indicated a new		appropriate safety intervention following each fall. The staff was also reminded that it is their responsibility to ensure that the fall interventions are being followed by all staff in accordance with each resident's individualized plan of care. The staff was also reminded to ensure that all med/tx carts are locked when not in direct use by the staff. F – 689 (continued) *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the effectiveness of the facility's fall prevention program. The tool will monitor to ensure that all appropriate fall follow up assessments are completed including neuro checks, per facility policy. The tool will monitor to ensure that an appropriate fall safety intervention has been put in place following each fall and added to the resident's care plan. The tool will also monitor to ensure that med/tx carts are secured when not in direct use by the staff. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the	

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	intervention to initiate appropriate intervention with care team following heat CT at the hospital. A new intervention was not added to the falls care plan following fall. The clinical record lacked neuro checks related to the fall. Fall 2 11/4/23 at 10:00 A.M. Resident tripped on the carpet in the hallway during ambulation. Fall was witnessed by a Qualified Medication Aide (QMA). Resident did not hit head. The fall incident report indicated a new intervention for "pt [patient] directly observed during ambulation". A new intervention was not added to the falls care plan following fall. Fall 3 12/2/23 at 4:50 P.M. Resident was transferring in the dining room without assistance and tripped over wheelchair, falling on buttocks on the floor. Fall was witnessed and resident did not hit head. The fall incident report indicated no immediate intervention "Resident assisted off floor et [and] all interventions in place and wheelchair functional and in working condition. Fall appears to be isolated even et result from resident transferring without assistance" A new intervention was not added to the falls care plan following fall. Fall 4 1/7/24 at 9:00 A.M. Resident slid out of chair in dining room while holding her walker, onto her back with walker at her side. Resident was assisted up and back to her room. Fall was witnessed, and resident did hit her head.		facility's Quality Assurance meetings to determine if any additional action is warranted.	

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The fall incident report indicated the immediate intervention was to place resident into wheelchair, and for the resident to utilize the wheelchair until a physical therapy evaluation. A new intervention was not added to the falls care plan following fall.

The clinical record lacked neuro checks related to the fall.

Fall 5
3/2/24 at 3:00 P.M. Resident was taken to the bathroom by staff and stated she needed a few minutes. Staff gave the resident the call string to pull when finished and left the area. The resident decided to go back to bed without assistance and fell hitting her face on the bedside table. Resident found laying on the left side with a raised hematoma to the left eye and a small laceration on the upper lip. The fall was unwitnessed.

The fall incident report indicated educated staff to stay with the resident while using bathroom and to be certain proper footwear is on.

The falls care plan was updated on 3/4/24 to include remaining with the resident during toileting as she will allow.

The clinical record lacked neuro checks related to the fall.

On 3/8/24 at 2:04 P.M., the ADON indicated staff was expected to stay just outside of the bathroom door when the resident requested privacy while using the toilet. Staff should provide the resident with a call light, but not leave the area while the resident was in the bathroom.

On 3/13/24 at 11:04 A.M., the MDS Coordinator

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	155508	A. BUILDING 00 B. WING	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE	725 S SECOND ST BOONVILLE, IN 47601

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	indicated care plan should be updated with every fall. She indicated often the IDT (interdisciplinary team) would meet without her and she would not know to update the care plan. In that case, someone else within the IDT should be updating care plan interventions. She indicated staff needed to be educated on updating care plan as needed. 3. On 3/5/24 at 1:17 P.M., Resident G was observed sitting in her room. At that time, she indicated she had recently fallen in the bathroom. Resident G initially indicated she had slipped on the bathroom floor, then indicated she had fallen when a resident came into the bathroom while she was using it, pushed her, and caused her to fall to the ground, hitting her head on the way down. On 3/5/24 at 1:50 P.M., Resident G's clinical record was reviewed. Diagnosis included, but were not limited to, epilepsy. The most recent Annual MDS Assessment, dated 3/5/24, indicated no cognitive impairment, and no behaviors. Resident G's clinical record lacked current physician orders related to interventions to prevent falls. A current risk for falls care plan included the following interventions: anticipate and meet the resident's needs, dated 6/2/23. follow facility fall protocol, dated 6/2/23. evaluate and treat as ordered or as needed, dated 6/2/23. Resident G experienced the following falls from 11/10/23 through 1/14/24:			

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	Fall 1 11/10/23 at 9:00 A.M. Resident was on the phone at the nurses station. She went to sit on her rolling walker as the walker rolled back and resident landed in a sitting position on the floor. Fall was witnessed and she did not hit her head. The falls incident report indicated the immediate intervention put into place to prevent further falls was that resident was reminded to lock rolling walker prior to standing or sitting. A new intervention was not added to the falls care plan following fall. Fall 2 12/3/23 at 7:00 A.M. Resident was found sitting on the floor next to the bed. The resident indicated she slid to the floor from the bed because of the slick comforter. Fall was not witnessed. The falls incident report indicated a new intervention to replace the comforter. A new intervention was not added to the falls care plan following fall. The clinical record lacked neuro checks related to the fall. Fall 3 12/30/23 at 3:30 P.M. Resident was trying on new clothes with family in her room when she lost balance and fell. The fall was witnessed by family, but not staff. The falls incident report indicated resident and family were educated on need for use of the walker. A new intervention was not added to the falls care plan following fall.			

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	The clinical record lacked neuro checks related to the fall. Fall 4 1/14/24 at 9:15 A.M. Resident was found lying on the floor of her bathroom following a large crash heard from the room. The resident was shouting that another resident had pushed her. The fall was not witnessed. A nurses note, dated 1/14/24 (entered as a late entry on 3/5/24) indicated after assessing the resident regarding the fall, the resident denied that the other resident had pushed her. She indicated she was going to the bathroom and fell. The falls incident report indicated the resident was moved to another room safely away from the other resident. A new intervention was not added to the falls care plan following fall. The clinical record lacked neuro checks related to the fall. On 3/12/24 at 12:52 P.M., the ADON indicated the intervention following Resident G's fall on 1/14/24 was not appropriate given the investigation following the fall. On 3/12/24 at 9:03 A.M., the ADON indicated care plans should be updated with a new intervention after each fall. She indicated all falls were reviewed in daily morning meetings and new interventions were put into place following that meeting. On 3/13/24 at 9:20 A.M., the ADON indicated neuro checks for Resident 31 and Resident G could not be located. 4. On 3/8/24 from 12:40 P.M. until 1:34 P.M., an			

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	unlocked treatment cart was observed sitting in the hallway just before the west hall near the nurses station. During that time, the following was observed: 12:45 P.M., the ADON (Assistant Director of Nursing) walked by. 12:49 P.M., Maintenance 29 walked by 3 times and CNA (Certified Nurse Aide) 7 walked by 2 times. 12:54 P.M., a visitor with a backpack walked by the cart; 1 anonymous resident wheeled past the cart; 1 anonymous resident walked by the cart. 12:55 P.M., CNA 7 and an anonymous resident with a walker walked by the cart. 12:56 P.M., OT (Occupational Therapist) 35 walked by the cart. 12:57 P.M., LPN (Licensed Practical Nurse) 21 walked by the cart. 12:59 P.M., LPN (Licensed Practical Nurse) 21 walked by the cart. 1:00 P.M., the Administrator and Maintenance 31 walked by the cart. 1:04 P.M., the SSD (Social Services Director) walked by, and LPN 13 looked at the cart and sat down at the nurses station. 1:05 P.M., the SSD, Maintenance Supervisor, and Housekeeping 12 walked by the cart. 1:07 P.M., Maintenance 31 walked by the cart. 1:08 P.M., the Maintenance Supervisor and Housekeeping 12 walked by the cart. 1:09 P.M., the Maintenance Supervisor walked by the cart. 1:10 P.M., LPN 14 left the nurses station and walked to the front of the building. At that time, the Maintenance Supervisor walked by the cart. 1:14 P.M., Maintenance 29, the Maintenance Supervisor, and Housekeeping 12 walked by the cart. 1:15 P.M., the SSD walked by the cart.			

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	1:16 P.M., the Maintenance Supervisor and an anonymous resident wheeled by the cart. 1:17 P.M., the Maintenance Supervisor walked by the cart. 1:18 P.M., Housekeeping 6 walked by the cart. 1:19 P.M., LPN 14 returned to the nurses station and Maintenance 31 walked by the cart. 1:20 P.M., Maintenance 29, Maintenance 31, and LPN 14 walked by the cart, and an anonymous resident wheeled by the cart. 1:21 P.M., an anonymous resident walked by the cart. 1:22 P.M., LPN 14, the SSD, and Maintenance 29 walked by the cart. 1:24 P.M., Maintenance 29 walked by the cart. 1:26 P.M., LPN 14 left the nurses station to go to the front of the building. 1:27 P.M., the SSD walked by the cart. 1:28 P.M., Housekeeping 6 and an anonymous resident walked by the cart. 1:31 P.M., an anonymous resident walked by the cart and LPN 14 returned to the nurses station. 1:32 P.M., Maintenance 29 walked by the cart. 1:33 P.M., an anonymous resident, Housekeeping 6, Maintenance 29, and Maintenance 31 walked by the cart. During an interview on 3/8/24 at 1:34 P.M., LPN 14 indicated the treatment cart should be locked at all times. The treatment cart was observed with the following items: 1 bandage, 1 clear syringe, 1 box of cough drops, a box of 90 tablets of Levocarnitine, a clear bag of nebulizer solution, and an orange bottle with calcium tablets. At that time, LPN 14 indicated she had to verify if the residents had an order for those medications or they would be thrown in the trash. On 3/13/24 at 12:48 P.M., a current non-dated Falls policy was provided and indicated "...the nurse			

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	should assess and document/report the following ... Neurological status ... The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling ... If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling ... and also reconsider the current interventions" On 3/13/24 at 12:49 P.M., the ADON provided an undated Security of Medication Cart policy that indicated, "...4. Medication carts must be securely locked at all times when out of the nurse's view . 5. When the medication cart is not being used, it must be locked..." 3.1-45(a)			
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to provide an RN (registered nurse) for 8	F 0727	F - 727 *The corrective action taken for*	04/12/2024

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	consecutive hours, seven days a week, for 2 of 7 days reviewed. Findings include: On 3/7/24 at 9:27 A.M., the review of nurse staffing from 2/20/24 through 2/27/24 indicated there was no RN coverage for 8 consecutive hours on 2/24/24 and 2/25/24. There was an RN working for 6 hours from 12 A.M. until 6 A.M. and 6 P.M. until 12 A.M. on 2/24/24. There was an RN working for 6 hours from 12 A.M. until 6 A.M. and 6 P.M. until 12 A.M. on 2/25/24. During an interview on 3/11/24 at 11:01 A.M., CNA 18 indicated she was the scheduler. She indicated an RN should be here every day but was not certain how many consecutive hours they should be in the building. On 3/11/24 at 10:55 A.M., the Administrator provided an undated Staffing, Sufficient and Competent Nursing Policy which indicated, "...3. A registered nurse provides services at least eight consecutive hours every 24 hours, seven days a week..." 3.1-17(b)(3)		*those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents have the potential to be affected by this deficient practice. The facility now has eight consecutive hours of RN coverage seven days a week. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. The facility now has eight consecutive hours of RN coverage seven days a week. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the Director of Nursing and the CNA identified as CNA 18 who is the staff scheduler on the Federal requirements for RN coverage. The staff members have been re-educated on their responsibility to ensure that each posted schedule has the required eight consecutive hours of RN coverage daily seven days a week. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the staffing schedule to ensure there are eight consecutive	

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			hours of RN coverage seven days a week on each posted schedule. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to			

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	residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure posted nurse staffing sheets were posted and contained the correct information daily for 3 of 9 days reviewed during the survey. (March 4, March 6, March 7) Findings include: On 3/4/24 at 8:37 A.M., the Posted Nurse Staffing sheet was observed laying on the East nurse's station ledge dated 3/1/24. On 3/6/24 at 8:18 A.M., the Posted Nurse Staffing sheet was observed laying on the East nurse's station ledge dated 3/5/24. On 3/7/24 at 8:30 A.M., there was no Posted Nurse Staffing sheet at the East nurse's station. On 3/7/24 at 2:16 P.M., there was no Posted Nurse Staffing sheet at the East nurse's station. During an interview on 3/11/24 at 11:01 A.M., CNA 18 indicated she filled out the Posted Nurse Staffing sheets. She put the sheets in a book and night shift posted them. She indicated they should be posted at midnight, and they should	F 0732	F - 732 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey all residents have the potential to be affected by this deficient practice. The daily nurse staffing posting is now being posted daily and contains all the correct required information. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. The daily nurse staffing posting is now being posted daily and contains all the correct required information. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the Director of	04/12/2024

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	contain the correct date. On 3/11/24 at 10:55 A.M., the Administrator provided an undated Posting Direct Care Daily Staffing Numbers Policy which indicated, "1. Within two hours of the beginning of each shift, the number of licensed nurses (RNs-Registered Nurses, LPNs-Licensed Practical Nurses, and LVNs-Licensed Vocational Nurses) and the number of unlicensed nursing personnel (CNAs-Certified Nursing Assistants and NAs-Nursing Assistants) directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in clear and readable format. 2. ...The information recorded on the form shall include the following:.. b. The current date (the date for which the information is posted)..."		Nursing and the Staffing scheduler on the facility's policy related to the posting of the direct care nursing staffing. The staff was reminded of their responsibility to ensure that these posting are accurate and are posted daily. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the posting of the direct care nursing staffing schedule. The tool will monitor to ensure that the posting in posted daily and that all required information is included in the posting and that the information is accurate. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a			

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	resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, interview, and record review, the facility failed to provide the necessary behavioral health monitoring to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care for 2 of 3 residents reviewed for behavior. Behavior monitoring was not accurately completed, and a care plan was not developed after behaviors observed. (Resident G, Resident H) Findings include: 1. On 3/5/24 at 1:17 P.M., Resident G was observed sitting in her room. At that time, she indicated she had recently fallen in the bathroom. Resident G initially indicated she had slipped on the bathroom floor, then later in the interview indicated she had fallen when a resident came into the bathroom while she was using it and pushed her. On 3/5/24 at 1:50 P.M., Resident G's clinical record was reviewed. Diagnosis included, but were not limited to, epilepsy. The most recent Annual MDS (Minimum Data Set) Assessment, dated 3/5/24, indicated no cognitive impairment, and no behaviors. Resident G's clinical record lacked current physician orders related to behaviors. Resident G's clinical record lacked a behavioral care plan related to accusations or false statements.	F 0740	F - 740 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the behavior that occurred with the resident identified as resident G was an isolated event. The resident had previously been evaluated by psych services and did not require any additional treatment and/or interventions. No additional behaviors have occurred since the isolated event. Should any new behaviors occur, the physician will be notified and behavioral monitoring and interventions will be developed and implemented into the resident's plan of care. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident H no longer resides at the facility. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit of all clinical records has been conducted to identify any resident with behaviors. Identified residents with behaviors are now being monitored each shift accurately for those identified behaviors and care	04/12/2024

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	Resident G's clinical record included, but was not limited to, the following fall: 1/14/24 at 9:15 A.M. Resident was found lying on the floor of her bathroom following a large crash heard from the room. The resident was shouting that another resident had pushed her. The fall was not witnessed. A nurses note, dated 1/14/24 (entered as a late entry on 3/5/24) indicated after assessing the resident regarding the fall, the resident denied that the other resident had pushed her. She indicated she was going to the bathroom and fell. Resident G's TAR (treatment administration record) for January 2024 lacked behavior monitoring. Resident G's clinical record lacked behavior monitoring prior to or after the incident on 1/14/24 related to accusations or false statements. On 3/12/24 at 10:03 A.M., the Assistant Director of Nursing (ADON) indicated Resident G's behavior of making false statements on 1/14/24 should have been identified as a new behavior and care planned so it could be monitored. She also indicated the physician should have been notified of the new behavior and was not. 2. On 3/8/24 at 9:38 A.M., Resident H's clinical record was reviewed. Diagnosis included, but were not limited to, schizoaffective disorder and Bipolar disorder. The most recent discharge MDS Assessment, dated 1/18/24, indicated Resident H experienced physical behaviors with others, verbal aggression with others and not toward others, and rejection of care. The most recent annual MDS Assessment, dated		plans have been developed and implemented including appropriate interventions to address the identified behaviors. Mental health services are also being provided for those residents in an attempt to improve those resident's overall well-being. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for social services and all nursing staff on the facility policy related to behavior tracking, behavioral health services and behavioral care planning. Staff members were re-educated on their responsibility to document behaviors and to follow each resident's individualized plan of care related to addressing identified behaviors. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implement to monitor the documentation of those residents with identified behaviors. The tool will monitor to ensure that behaviors are being tracked accurately and that the behavioral care plan is in place and being followed by staff members in an effort to improve the resident's overall well-being. This tool will be completed by Social Services and/or their designee weekly for four weeks,	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1/9/24, indicated no cognitive impairment. Physician orders included, but were not limited to, the following: Antianxiety medication - monitor for aggressive/impulsive behavior, dated 1/20/22. Antipsychotic medication - monitor for increased agitation, dated 1/20/22. Resident H's care plans included, but were not limited to, the following: Potential to have a behavior problem related to diagnosis of schizoaffective disorder and bipolar disorder, dated 3/28/22. Psychosocial/behavior: altered perceptions including delusions/hallucinations and often expresses events that have not happened, can be difficult to redirect, dated 3/28/22. Sometimes has behaviors of outbursts as exhibited by knocking off items from desk, yelling, cursing, and name calling related to schizophrenia, dated 10/3/22. Progress notes included, but were not limited to, the following: 1/13/24 at 12:36 P.M. Behavior Note "Notified by 2 other residents who were shouting that this resident had punched another resident in the right shoulder. This resident was seen by staff walking away from the other two. Notified Executive Director and NP [Nurse Practitioner]. New orders to send this resident to [hospital emergency department] for evaluation and treatment of aggressive behaviors. [emergency medical services] notified, who responded along with [police department]. While attempting to get resident onto the ambulance stretcher, she began		then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	155508	A. BUILDING 00 B. WING	03/14/2024

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	striking the paramedic in the face several times, causing the police officer to physically restrain the resident. Resident then left the facility without further incident" Resident returned to the facility same day. 1/14/24 at 9:20 A.M. Behavior Note "Resident heard shouting from her room following a large crash. Upon arrival found resident standing near the doorway of her bathroom while another resident was lying on the bathroom floor. Resident denies striking or pushing other resident. No visible injuries to resident" 1/14/24 at 9:22 A.M. Behavior Note Nurse Practitioner and Administrator notified. 1/14/24 at 10:43 A.M. Administration Note "Geodon [an antipsychotic medication] Intramuscular Solution Reconstituted Inject 10 mg [milligrams] intramuscularly every 2 hours as needed for Aggressive behaviors May repeat dose in 2 hours if ineffective" 1/14/24 at 10:49 A.M. Nurse communication with physician "Spoke with NP [name] regarding resident increase in physical aggressive behaviors. New order in place to administer 10 mg of Geodon IM now, may repeat dose in 2 hours if ineffective" Resident H's TAR for January 2024 indicated aggressive/impulsive behaviors were not observed on the following dates: 1/3/24 day and night shift 1/4/24 day and night shift 1/5/24 day and night shift 1/6/24 night shift 1/7/24 night shift			

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	1/8/24 through 1/15/24 day and night shift Resident H's TAR for January 2024 indicated aggressive/impulsive behaviors were only observed on 1/6/24 and 1/7/24 day shift. On 3/14/24 at 9:33 A.M., the MDS Coordinator provided a behavior monitoring report for January 2024 that indicated from 1/6/24 through 1/17/24, no behaviors were observed. On 3/5/24 at 9:56 A.M., Licensed Practical Nurse (LPN) 5 indicated Resident H had a lot of psych issues, and had shared a bathroom with another resident. On 1/14/24, staff heard a crash coming from their bathroom, and upon entering, found Resident H standing in the doorway with the other resident on the bathroom floor. At that time, the other resident indicated Resident H had pushed her, but then later redacted that information. LPN 5 indicated later that day, Resident H's aggression with other residents got worse, so the Nurse Practitioner was notified and Resident H was given an antipsychotic medication order related to the behavior. On 3/13/24 at 12:48 P.M., a current non-dated Behavior Assessment and Monitoring policy was provided and indicated "The nursing staff will identify, document, and inform the physician about an individual's mental status, behavior, and cognition ... The staff will document (either in progress notes, behavior assessment forms, or other comparable approaches) the following information about specific problem behaviors ... Number and frequency of episodes ... Preceding or precipitating factors ... Interventions attempted ... Outcomes associated with interventions" 3.1-43(a)			

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F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to ensure medically-related social services were provided to residents for 1 of 2 residents reviewed for dental services and 1 of 1 resident leaving the building. Staff was unsure if a resident had dentures or not for Resident 14 and Resident 41 was assisted to leave the building without first verifying there was a physician order to leave, to leave with medication. (Resident 14, Resident 41) Findings include: 1. During an interview on 3/4/24 at 10:13 A.M., Resident 14 indicated someone took her dentures. On 3/5/24 at 1:27 P.M., Resident 14 was observed talking with other residents without her dentures while in the dining room. On 3/11/24 at 8:57 A.M., Resident 14's clinical record was reviewed. Diagnoses included, but were not limited to, dementia without behavioral disturbance. The most recent Quarterly MDS Assessment, dated 2/1/24, indicated Resident 14's cognition was moderately impaired and an extensive assist of 1 staff for bed mobility, transfers, toileting, and eating. A current "[name of resident] has dentures, but prefers not to wear them" Dental Care Plan,	F 0745	F - 745 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the facility has discussed the missing dentures with the guardian of the resident identified as resident 14. The guardian has elected that due to the resident not having any chewing or swallowing problems at this time, the guardian has declined any dental referral for new dentures. Social services and nursing will continue to monitor this situation and if any problems or concerns develop the issue will be pursued further. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 41 no longer resides at the facility. It should be noted however, that there was an LOA with medications order in the clinical record. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice.	04/12/2024

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	revised 2/28/24, included, but were not limited to, the following interventions: Please make sure to remind her to remove and clean dentures daily and as needed, initiated 11/5/20 Please watch that dentures continue to fit proper, initiated 11/5/20 The clinical record lacked documentation indicating staff was aware of the missing dentures. Resident grievances for the last 6 months were requested, provided, and reviewed. There was not a grievance for Resident 14's dentures. During an interview on 3/11/24 at 9:12 A.M., RN 9 indicated that Resident 14 hasn't had dentures that she knows of since she's worked there but will check with the Social Services Director (SSD) to make sure. During an interview on 3/13/24 at 10:13 A.M., the MDS Coordinator indicated there should be a grievance because SSD was aware of the dentures missing. During an interview on 3/13/24 at 9:34 A.M., the Assistant Director of Nursing (ADON) indicated she was not aware that Resident 14 was missing dentures and unsure if she even had dentures. During an interview on 3/13/24 at 10:40 A.M., the SSD indicated about a week ago, Resident 14 came to her and said she had lost her dentures. She indicated she had searched the resident's room and they were not found. At that time, the SSD could not verify if Resident 14 had dentures or not. She indicated she was not sure how to		A housewide audit of all residents has been conducted to identify any medically related social service needs of the residents. No specific needs or concerns were identified by the residents at the time of this review. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service was provided for the social service director to review the social service job description. The staff member was re-educated on their responsibility to meet the medically related social service needs of each resident. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the medically related social service needs of the residents to ensure that all needs are being met for each resident. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	document the situation in the resident's chart and had consulted with the Administrator about how to document it but had not heard back from her yet. During an interview on 3/13/24 at 10:43 A.M., the Administrator indicated Resident 14 did have dentures and the SSD was aware that they were lost. She was unsure why there was no documentation of the situation. 2. On 3/05/24 at 1:27 P.M., Resident 41's clinical records were reviewed. He was admitted on 12/7/23. Diagnosis included, but was not limited to cerebral infarction, chronic embolism and thrombosis of bilateral lower extremities, chronic pain due to trauma, depression, atherosclerotic heart disease of native coronary artery. The most current State optional, Quarterly MDS Assessment, dated 1/29/24, indicated Resident 41 was cognitively intact, and needed extensive assistance of one for bed mobility, transfer, eating and toilet use. Progress Notes included, but was not limited to the following: 3/4/2024 1:34 P.M. Social Services Note "Note Text: [Resident's name] went to NS [Nurse's State] to request CNA [Certified Nursing Assistant] call him a cab so that he can go to Bowling Green, Kentucky. CNA notified SSD [Social Services Designee] and SSD spoke to [Resident's name] at this time. [Resident's name] stated that he had an appointment with [doctor's name] in Bowling Green, Kentucky [101 miles away] that he needed to leave for a few days to go to this appointment. SSD attempted to explain that facility can call and schedule his appointments and provide transportation. [Resident's name] declined at this time stating that he just wanted to			

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	go see his doctor. SSD asked how long he would need to go LOA [Leave of Absence] for, [Resident's name] stated 2 or 3 days. [Resident's name] has a history of leaving facility AMA [Against Medical Advice]. SSD explained the importance of getting discharge orders from the MD [Medical Doctor]. [Resident's name] was adamant that he was not leaving AMA but that he just needed to go LOA to go to an appointment. [Resident's name] to call cab company and get ride to Bowling Green. LOA meds [medications] provided by nurse. 3/4/2024 2:39 P.M. Social Services Note "Note Text: Nursing states [Resident's name] is A&Ox3 [Alert and oriented 3 times]. [Resident's name] BIMS [Brief Interview for Mental Status] score of 15. SSD assisted [Resident's name] in calling cab company. 30-45 minute wait. [Resident's name] aware." 3/4/2024 3:40 P.M. Alert Note Note Text: Cab here to get resident for LOA. Resident left facility with medications x3 [for 3] days, med [medication] list, et [and] belongings. 3/8/2024 9:03 A.M. IDT (Interdisciplinary Team) note Attendance: ED (Executive Director), ADNS (Assistant Director of Nursing Services), DNS (Director of Nursing Services), SSD, MDS (Minimum Data Set) "Notes: Resident went out for LOA on 3/4/2024 with a return date of 3/7/2024. At this time, resident still has not returned to the facility. SSD contacted local hospitals, urgent cares, hotels and the clinic resident stated he was going to. SSD also contacted thecab [sic] company that resident used and confirmed that they dropped him off at [address] in Bowling Green, Kentucky. SSD			

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	contacted the hotel at this address, and they stated that resident is not there. ED contacted [Name of County] Sheriff's office and spoke operator [name] and they are initiating a welfare check. SSD contacted the Ombudsman, [name] by email and phone. RN contacted Indiana Adult Protective Services and spoke with [name]. [Name] stated that since resident had gone into Kentucky RNmust [sic] call Kentucky APS [Adult Protective Services]. RN then called Kentucky APS and spoke with [name] and gave all necessary information to file report. Case number per (name) is [number]. MD and NP [Nurse Practitioner] notified that resident has not returned to the facility at this time." Resident 41's clinical record lacked an order for resident to leave the facility. Resident 41's clinical record lacked notification of physician prior to calling a cab for the resident. Resident 41's clinical record lacked documentation of follow up until questioned. During on interview on 3/6/24 at 9:58 A.M., motel #1 staff of address provided by SSD indicated resident has not checked into their motel since June of 2023, did not check in on 3/4/24 and was not there now. During an interview on 3/6/24 at 10:18 A.M., the Cab Driver indicated she did pick up Resident 41 at this facility and drove him to Bowling Green, Kentucky (motel name different motel than above). Indicated he did change his mind when they got to Bowling Green, Kentucky and wanted to stay at (motel name #2) instead of (motel name #1). She indicated he told her he lost his home and was going to stay at (motel) now. He did not talk			

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	much during the trip and did not tell her his plans while he was in (city of Bowling Green). He did not tell her he would need a cab ride back to this facility. During an interview on 3/6/24 at 10:30 A.M., motel #2 staff indicated Resident 41 arrived on 3/4/24 and was booked to stay for 1 week. On 3/13/24 at 1:34 P.M., a current Social Worker (SSD) Job Description, revised 2010, was requested and provided by the ADON and indicated "The primary purpose of your job position is to assist in planning, organizing, implementing, evaluating, and directing the overall operation of our facility's Social Services Department ... to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis ... job duties/responsibilities: ... Ensure that all charted progress notes are informative and descriptive of the services provided and of the resident's response to the service ... Assist in developing a written plan of care (preliminary and comprehensive) for each resident that identifies the problems/needs of the resident ...Maintain a written record of the resident's complaints and/or grievances that indicates the action taken to resolve the complaint and the current status of the complaint ... " On 3/13/24 at 1:34 P.M., a current Grievance Policy, dated 1/6/19, was provided by the ADON and indicated " ... Our facility will assist residents, their representatives (sponsors), file grievances or complaints when such requests are made ... Upon receipt of a grievance and/or complaint, the Executive Director or his/her designee will investigate the allegations and submit a written report of such findings within five (5) working			

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	days of receiving the grievance and/or complaint. 3.1-34(a)(1)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and			

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	periodically reconciled. Based on interview and record review, the facility failed to ensure accurate dispensing and administration of medications for 1 of residents reviewed for hospitalizations. A resident's controlled medications were documented as given during a hospitalization, and after a change to the order resulting in missing doses. (Resident J) Findings include: On 3/5/24 at 9:01 A.M., Resident J's clinical record was reviewed. Admission date was 6/2/23. Diagnosis included, but were not limited to, dementia, anxiety, depression, and schizophrenia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 2/6/24, indicated cognition status could not be obtained. Resident J had received antipsychotic, antianxiety, antidepressant, antibiotic, diuretic, and opioid medications. Physician orders included, but were not limited to, the following: Clonazepam 0.5 mg (milligram) at bedtime for anxiety, dated 1/30/24 (current order). Clonazepam 0.5 mg three times a day for anxiety, from 8/16/22 through 1/30/24. A hold was put on the order from 1/25/24 through 1/28/24 and from 1/28/24 through 1/30/24. Resident J was hospitalized from 1/22/24 at 11:22 A.M. through 1/30/24 (discharged at 2:55 P.M.). Resident J's MAR (medication administration record) for January 2023 indicated clonazepam 0.5 mg (three times a day) was administered on 1/25/24 at 1:00 P.M. by Qualified Medication Aide (QMA) 25. All other doses from 1/22/24 at 1:00	F 0755	F - 755 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident J is now receiving all of their medications in accordance with the current physician's orders. The QMAs identified as QMA 25 and QMA 27 have received a teachable moment related to ensuring that medications are administered in accordance with the resident's physician's orders and not documented as being given on the MAR when a medication is held for any reason. The LPN identified as LPN 5 also received a teachable moment related to their medication and documentation error. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all controlled substances has been conducted to ensure that the controlled substance record matches the documentation on the resident's MARs. No other discrepancies were identified. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has	04/12/2024

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	P.M. through 1/25/24 at 7:00 P.M. were documented that the resident was away from home or at the hospital. From 1/26/24 at 7:00 A.M. through 1/30/24 at 1:00 P.M., the MAR indicated the medication was on hold. Resident J's MAR for January 2023 indicated clonazepam 0.5 mg (once a day) was administered 1/30/24 and 1/31/24. On 3/11/24 at 9:50 A.M., the Assistant Director of Nursing (ADON) was made aware of the discrepancies found in Resident J's medication administration. At that time, she indicated nurses were expected to sign off on the medications as they were given in the resident's MAR as well as the Controlled Substance Accountability forms. On 3/11/24 at 10:04 A.M., Resident J's Controlled Substance Accountability form was reviewed with the following information from 1/21/24 through 2/1/24 for the administration of clonazepam 0.5 mg: 1/21/24 dispensed: 3 with 3 total remaining 1/22/24 administered: 1 at 6:00 A.M. with 2 total remaining 1/22/24 administered: 1 at 12:00 P.M. with 1 total remaining 1/22/24 dispensed: 3 with 4 total remaining 1/23/24 destroyed: 1 with 3 total remaining 1/25/24 none dispensed, administered, or destroyed with 3 total remaining 1/27/24 none dispensed, administered, or destroyed with 3 total remaining 1/31/24 administered: 1 at 6:00 A.M. with 2 total remaining 1/31/24 administered: 1 at 12:00 P.M. with 1 total remaining 1/31/24 dispensed: 3, administered: 1 with 2 total remaining (1 dose missing. Count should have been 3 total remaining)		been provided for all licensed nurses and QMAs on the facility's policies related to medication administration and controlled substance documentation. The staff was re-educated on their responsibility to ensure that each resident receives their medications as ordered by the physician and that all medication administration is accurately documented in the clinical record in accordance with facility policy. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the administration of medication in accordance with the resident's physician's orders. The tool will monitor to ensure there is documentation to support on the MAR and the controlled substance record that the resident has received all of their medication as currently ordered by their physician. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	155508	A. BUILDING 00 B. WING	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE	725 S SECOND ST BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2/1/24 destroyed: 2 2/1/24 dispensed: 2 with 2 total remaining (still 1 dose missing. Count should be 3) 2/1/24 administered: 1 with 1 total remaining (still 1 dose missing. Count should be 2) On 3/11/24 at 10:22 A.M., the East and West Hall medications carts were observed and all controlled substances reconciled. All medications were accounted for in the carts. On 3/11/24 at 10:56 A.M., the ADON indicated QMA 27 had given Resident J the noon dose of clonazepam on 1/22/24 just before leaving for the hospital. (documented as given on the Controlled Substance Accountability form, and documented as not given on the resident's MAR) On 3/11/24 at 11:24 A.M., the ADON provided a dispense report for Resident J's clonazepam from 1/1/24 through 3/11/24. The form indicated the following doses were dispensed around the time of Resident J's hospitalization: On 1/21/24 at 3:54 P.M., 3 doses were dispensed for date of administration 1/22/24. On 1/22/24 at 7:54 P.M., 3 doses were dispensed for date of administration 1/23/24. On 2/1/24 at 12:56 P.M., 2 dosed were dispensed for dates of administration 2/1/24 and 2/2/24. On 3/12/24 at 8:29 A.M., the ADON indicated QMA 25 had told her she must have checked off on giving Resident J a dose of clonazepam on 1/25/24 without actually giving the medication, as she was going from one resident to the next signing off on what was due on the MAR. On 3/13/24 at 8:52 A.M., the Administrator indicated that the ADON had investigated Resident J's alleged missing medications, the			

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	ADON spoke with the nurses that signed off on them, and they all told her they had marked them accidentally. On 3/13/24 at 8:57 A.M., the ADON indicated the investigation into the alleged missing medications was complete and determined that the nurses had been clicking too fast on the resident's MAR and clicked off as being given, although it had not been. On 3/13/24 at 9:20 A.M., Resident J's Controlled Substance Accountability forms were reviewed with the ADON. At that time, she indicated no other forms could be located to account for what happened to the missing medications and a more thorough investigation needed to be done to determine what happened, as there were 2 doses that should be left that were not given. On 3/13/24 at 10:30 A.M., Clinical Support indicated since the bottom of the count sheet indicated 2 doses had been destroyed, it was only an error on the nurses part by signing off on the sheet for 1/31/24 at 6:00 A.M. and 12:00 P.M. On 3/13/24 at 10:53 A.M., Licensed Practical Nurse (LPN) 5 indicated it was his signature on Resident J's Controlled Substance Accountability form on 1/31/24 at 6:00 A.M. and 12:00 P.M. He indicated he did not remember exactly what happened, but if it was signed off as being taken out of the cart, he must have pulled it and given it to the resident. On 3/13/24 at 12:48 P.M., the ADON provided a current non-dated Controlled Substances policy that indicated "Controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances			

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	together. Both individuals sign the designated controlled substance record ... Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up" 3.1-25(a)(3) 3.1-25(e)(3)			
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to serve food at an appetizing temperature for 1 of 1 lunch trays tested. (East Hall) Finding includes: On 3/8/24 at 12:29 P.M., a lunch tray was obtained from the East Hall with the following temperatures: Beef stroganoff: 120.6 degrees Fahrenheit Green beans: 104.1 degrees Fahrenheit At that time, Licensed Practical Nurse (LPN) 21 indicated residents would normally complain about the breakfast temperatures, but not as often for lunch.	F 0804	F - 804 *The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents on the East Hall are now being served their meals at the proper food temperatures. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. All meal trays are now being served to each resident with foods	04/12/2024

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	On 3/8/24 at 1:35 P.M., the Kitchen Manager indicated hot foods should be served to residents at 165 degrees Fahrenheit or higher, but may lose 20 degrees or so coming down the hall. On 3/13/24 at 12:48 P.M., a current non-dated Food and Nutrition Services policy was provided and indicated "Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking in to consideration the preferences of each resident" The policy did not indicate serving temperatures of foods. 3.1-21(a)(2)		that are maintained at the proper food temperatures. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all dietary and nursing staff on the facility's policies related to food preparation and service as well as the policy on food and nutritional services. The staff was instructed on ensuring that all meal trays are served in a timely manner to ensure food temperatures are maintained. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor meal service to ensure food temperatures are maintained. The tool will monitor actual food temperatures of test trays as well as conduct interviews of residents related to meal satisfaction. This tool will be completed by the Food Service Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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F 0812 SS=E 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 standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure storage of food in a safe and sanitary manner for 2 of 2 kitchen observations. Open food items were observed unlabeled and open to air, debris was observed on the floor, and the window screen was observed damaged in the dishwasher area. Findings include: On 3/4/24 at 8:28 A.M., the following was observed in the kitchen: A pitcher of yellow substance was in the refrigerator with no label or date. A package of Canadian bacon was open to air	F 0812	F - 812 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. All of the food items listed during the survey that were open to air, not labeled or dated located in the refrigeration and/or freezer have been discarded. All new food items and beverages that	04/12/2024

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	with no label or open date in the refrigerator. A package of Canadian bacon was open and in a separate baggie with no label or open date. Slices of lunch meat were in a baggie in the refrigerator with no label or open date. A baggie of yellow cheese slices were in the refrigerator open to air with no label or open date. A baggie of white cheese slices were in the refrigerator with no label or open date. Shredded cheese was observed wrapped in cling wrap with no label or open date. The floor of the refrigerator was observed wet. A bag of meat patties were observed in the freezer open to air with no label or open date. The floor of the freezer was observed with ice. Debris was observed on the kitchen floor under the sink area, under the table with the microwave, on the puree blender, and under the dishwasher counter. Debris was observed inside the juice machine just under the juice containers. The window by the dishwasher was observed with three large holes in the screen. The air condition window unit by the dishwasher was observed with duct tape surrounding it and black spots on and around the tape. Dust was observed caked in the slats of the unit. On 3/7/24 at 11:34 A.M., the following was observed in the kitchen: A bag of meat patties were observed in the freezer open to air with no label or open date. The floor of the freezer was observed with ice. The air condition window unit by the dishwasher was observed with duct tape surrounding it and black spots on and around the tape. Dust was observed caked in the slats of the unit. At that time, the Kitchen Manager indicated she was unsure what all needed to be labeled, and was in the process of labeling everything.		have been received are properly covered, labeled and dated when received and/or opened. The refrigerator has been deep cleaned and no longer has water on the floor of the refrigerator. The floor of the freezer has been cleaned and no longer has ice present on the floor. The kitchen floor has been deep cleaned and placed on a routine cleaning schedule. There is no now debris on the kitchen floor. The juice machine has been deep cleaned and there is no debris in or under the juice machine. The juice machine has been placed on a routine cleaning schedule. The screen in the window above the dishwasher has been replaced with a new screen and is free of holes. The air conditioner window unit by the dishwasher has been cleaned and is now free of dust and contains no black spots. The air conditioner unit has now been placed on a routine cleaning schedule. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. All of the food items listed during the survey that were open to air, not labeled or dated located in the refrigeration and/or freezer have been discarded. All new food items and	

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	On 3/13/24 at 12:48 P.M., a current Food Receiving and Storage policy, dated 10/22/17, was provided and indicated "Foods shall be received and stored in a manner that complies with safe food handling practices ... Food services, or other designated staff, will maintain clean food storage areas at all times ... All foods stored in the refrigerator or freezer will be covered, labeled and dated" 3.1-21(i)(2) 3.1-21(i)(3)		beverages that have been received are properly covered, labeled and dated when received and/or opened. The refrigerator has been deep cleaned and no longer has water on the floor of the refrigerator. The floor of the freezer has been cleaned and no longer has ice present on the floor. The kitchen floor has been deep cleaned and placed on a routine cleaning schedule. There is no now debris on the kitchen floor. The juice machine has been deep cleaned and there is no debris in or under the juice machine. The juice machine has been placed on a routine cleaning schedule. The screen in the window above the dishwasher has been replaced with a new screen and is free of holes. The air conditioner window unit by the dishwasher has been cleaned and is now free of dust and contains no black spots. The air conditioner unit has now been placed on a routine cleaning schedule. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all dietary staff on the facility's policies related to Food Receiving & Storage, Food Preparation & Service, and the Dietary Cleaning Schedules. All dietary staff was re-educated on these policies to ensure their	

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			knowledge of their responsibility in following all facility policies related to food safety and dietary sanitation. F – 812 (continued) *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor safety and cleanliness in the storage, preparation and serving of food in the dietary department. The tool will monitor to ensure the proper handling/storage of all food/beverage items, proper sanitation in the preparation and serving of meals, cleanliness of all dietary equipment, etc. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is			

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	resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss,			

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	destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observation, interview, and record review the facility failed to maintain accurate medical records on 3 of 27 residents reviewed. (Resident 41, Resident G, Resident J) Findings include: 1. On 3/05/24 at 1:27 P.M., Resident 41's clinical records were reviewed. He was admitted on 12/7/23. Diagnosis included, but was not limited to cerebral infarction, chronic embolism and thrombosis of bilateral lower extremities, chronic pain due to trauma, depression, atherosclerotic heart disease of native coronary artery. The most current State optional, Quarterly MDS	F 0842	F - 842 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 41 no longer resides at the facility. Resident 41 had a BIMS score of 15, was their own responsible party and had the resident's rights to go on a leave of absence. The resident apparently decided to not return from the leave of absence and the facility made every effort to make contact with the resident including notifying the ombudsman and law	04/12/2024

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	Assessment, dated 1/29/24, indicated Resident 41 was cognitively intact, and needed extensive assistance of one for bed mobility, transfer, eating and toilet use. Progress Notes included, but was not limited to the following: 3/4/2024 1:34 P.M. Social Services Note "Note Text: [Resident's name] went to NS [Nurse's State] to request CNA [Certified Nursing Assistant] call him a cab so that he can go to Bowling Green, Kentucky [101 miles away]. CNA notified SSD [Social Services Designee] and SSD spoke to [Resident's name] at this time. [Resident's name] stated that he had an appointment with [doctor's name] in Bowling Green, Kentucky and that he needed to leave for a few days to go to this appointment. SSD attempted to explain that facility can call and schedule his appointments and provide transportation. [Resident's name] declined at this time stating that he just wanted to go see his doctor. SSD asked how long he would need to go LOA [Leave of Absence] for, [Resident's name] stated 2 or 3 days. [Resident's name] has a history of leaving facility AMA [Against Medical Advice]. SSD explained the importance of getting discharge orders from the MD [Medical Doctor]. [Resident's name] was adamant that he was not leaving AMA but that he just needed to go LOA to go to an appointment. [Resident's name] to call cab company and get ride to Bowling Green. LOA meds [medications] provided by nurse. 3/4/2024 2:39 P.M. Social Services Note "Note Text: Nursing states [Resident's name] is A&Ox3 [Alert and oriented 3 times]. [Resident's name] BIMS [Brief Interview for Mental Status] score of 15. SSD assisted [Resident's name] in calling cab company. 30-45 minute wait.		enforcement which was documented in the clinical record. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the documentation of the administration of medication and treatments of the resident identified as resident J who was in the hospital at the time of the documentation, was done in error by RN 9. A teachable moment has been provided for RN 9 on their responsibility to ensure that the documentation of medications/treatments must be completed accurately for each resident. The resident identified as resident J is now receiving their medications and treatments in accordance with the physician's orders and the documentation in the clinical record is accurate to reflect the administration of medications/treatment. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the documentation on the resident identified as resident G was transcribed in error. The nurse responsible for the error in the documentation has received a teachable moment on their responsibility to ensure that all documentation in the clinical record is to accurately reflect the resident's condition/issues. *The corrective action taken for the other residents that have the*	

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	[Resident's name] aware. 3/4/2024 3:40 P.M. Alert Note Note Text: Cab here to get resident for LOA. Resident left facility with medications x3 [for 3] days, med [medication] list, et [and] belongings. 3/8/2024 9:03 A.M. IDT (Interdisciplinary Team) note Attendance: ED (Executive Director), ADNS (Assistant Director of Nursing Services), DNS (Director of Nursing Services), SSD, MDS (Minimum Data Set) "Notes: Resident went out for LOA on 3/4/2024 with a return date of 3/7/2024. At this time, resident still has not returned to the facility. SSD contacted local hospitals, urgent cares, hotels and the clinic resident stated he was going to. SSD also contacted thecab [sic] company that resident used and confirmed that they dropped him off at [address] in Bowling Green, Kentucky. SSD contacted the hotel at this address, and they stated that resident is not there. ED contacted [Name of County] Sheriff's office and spoke operator [name] and they are initiating a welfare check. SSD contacted the Ombudsman, [name] by email and phone. RN contacted Indiana Adult Protective Services and spoke with [name]. [Name] stated that since resident had gone into Kentucky RNmust [sic] call Kentucky APS [Adult Protective Services]. RN then called Kentucky APS and spoke with [name] and gave all necessary information to file report. Case number per (name) is [number]. MD and NP [Nurse Practitioner] notified that resident has not returned to the facility at this time." During on interview on 3/6/24 at 9:58 A.M., motel #1 staff of address SSD provided indicated resident has not checked into their motel since		*potential to be affected by the same deficient practice is that* a housewide audit of all clinical record documentation over the past thirty days has been conducted to identify any additional documentation errors. No additional documentation errors were identified. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses and QMAs on their responsibility to ensure that all entries in the clinical record are accurate and reflect the specific care and services that have been provided for the resident and/or describe the resident's current condition/issue. F – 842 (continued) *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the accurate of the information that has been entered into the clinical record. The tool will monitor to ensure that all entries contain accurate information based on the	

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	June of 2023, did not check in on 3/4/24 and was not there now. During an interview on 3/6/24 at 10:18 A.M., the Cab Driver indicated she did pick up Resident 41 at this facility and drove him to Bowling Green, Kentucky to (motel name different than the one above). Indicated he did change his mind when they got to Bowling Green and wanted to stay at (motel name #2) instead of (motel name #1). She indicated he told her he lost his home and was going to stay at (motel) now. He did not talk much during the trip and did not tell her his plans while he was in Bowling Green. He did not tell her he would need a cab ride back to this facility. During an interview on 3/6/24 at 10:30 A.M., motel #2 staff indicated Resident 41 arrived on 3/4/24 and was booked to stay for 1 week. 2. On 3/5/24 at 9:01 A.M., Resident J's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, depression, and schizophrenia. The most recent Quarterly MDS Assessment, dated 2/6/24, indicated cognition status could not be obtained. Resident J was hospitalized from 1/22/24 at 11:22 A.M. through 1/30/24 (discharged at 2:55 P.M.). Resident J's MAR (medication administration record) for January 2024 indicated the following: ducosate sodium 100mg administered by Registered Nurse (RN) 9 on 1/25/24 at 6:00 A.M. Lasix 20mg was administered by RN 9 on 1/23/24 and 1/25/24 at 6:00 A.M. Resident J's TAR (treatment administration record) for January 2024 indicated the following: monitoring for reactions to antianxiety medication		resident's current status/condition. The tool will also monitor to ensure that all care and services, such as medications and treatments documented have been provided in accordance with the resident's physician's orders and plan of care. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	was completed 1/22/24 night and day shift, 1/23/24 night shift, 1/24/24 night shift, and 1/25/24 day shift. monitoring for reactions to antipsychotic medication was completed 1/22/24 night and day shift, 1/23/24 night shift, 1/24/24 night shift, and 1/25/24 day shift. bilateral enablers for bed mobility and positioning was completed 1/22/24 night and day shift, 1/23/24 night shift, 1/24/24 night shift, and 1/25/24 day shift. droplet precautions for positive influenza test was checked 1/22/24 night and day shift, 1/23/24 night shift, 1/24/24 night shift, and 1/25/24 day shift. may elevate head of the bed after meals due to reflux was checked 1/22/24 night and day shift, 1/23/24 night shift, 1/24/24 night shift, and 1/25/24 day shift. monitoring for reactions to antidepressant medication completed 1/22/24 night and day shift, 1/23/24 night shift, 1/24/24 night shift, and 1/25/24 day shift. monitoring for pressure relieving and reducing mattress completed 1/22/24 night and day shift, 1/23/24 night shift, 1/24/24 night shift, and 1/25/24 day shift. turn and reposition approximately every 2 hours completed 1/22/24 night and day shift, 1/23/24 night shift, 1/24/24 night shift, and 1/25/24 day shift. On 3/11/24 at 9:50 A.M., the Assistant Director of Nursing (ADON) indicated the nurses were			

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	expected to sign off on the medications as they were given. On 3/12/24 at 10:55 A.M., RN 9 indicated she had clicked off on giving Resident J ducosate sodium and lasix on 1/25/24 in error. On 3/13/24 at 9:20 A.M., the Clinical Support indicated medications and treatments should have been accurately documented and was part of the nurse's job description. Education was given on an as needed basis. 3. On 3/4/24 at 10:42 A.M., Resident G was observed sitting on the bed. Resident G was missing her front teeth. Several other teeth were observed broken in spots and all had a white filmy substance between them. On 3/5/24 at 1:50 P.M., Resident G's clinical record was reviewed. Diagnosis included, but were not limited to, epilepsy. The most recent annual MDS Assessment, dated 3/5/24, indicated no cognitive impairment, and no dental concerns. Progress notes included the following information from skilled evaluations filled out by nursing staff: No broken teeth documented on: 2/11/24 2/19/24 2/24/24 Broken teeth documented on: 1/31/24 2/6/24 2/14/24 2/25/24 3/1/24 3/4/24			

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	Teeth not assessed on: 12/3/24 2/1/24 2/5/24 2/9/24 2/10/24 2/16/24 2/17/24 2/18/24 2/23/24 Resident G received the influenza vaccine on 9/1/23. Progress notes included, but were not limited to, the following: 1/20/24 at 2:08 P.M. Infection Note: "Resident tested for outbreak testing ... resulted positive after 15 minutes of processing time ..." 1/21/24 at 8:03 A.M. "f/u [follow up] flu vaccine t [temperature] 97.6 no cough noted. in bed with eyes closed" On 3/12/24 at 10:03 A.M., the ADON indicated the follow up flu vaccine progress note had been written in error and should have been a follow up for flu positive. On 3/13/24 at 12:48 P.M., the ADON provided a current non-dated Charge Nurse job description and indicated the form was a policy for nurse job duties. The form indicated charting and documentation should be completed "... in an informative and descriptive manner that reflects the care provided to the resident, as well as the resident's response to the care ... Perform routine charting duties as required and in accordance with established charting and documentation policies			

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	and procedures" 3.1-50(a)(2)			
F 0851 SS=F Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);			

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	(ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. Based on record review and interview, the facility failed to electronically submit to CMS (Center for Medicare and Medicaid Services) required information regarding direct care staffing for Fiscal Quarter 4 from 7/1/23 thru 9/30/23. Findings Include: During an interview on 3/7/24 at 9:37 A.M., the Administrator indicated PBJ (Payroll-Based Journal) information was submitted by staff outside of the facility. On 3/8/24 at 2:13 P.M., the Administrator provided a copy of the Casper Report 1702S, Staffing	F 0851	F - 851 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents have the potential to be affected by the deficient practice. The facility administrator is now responsible for the submission of the PBJ information in accordance with the CMS schedule and will no longer be submitted by an outside resource.	04/12/2024

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	Summary Report from 7/1/23 thru 9/30/23, which indicated "No data returned for selected criteria." On 3/11/24 at 10:53 A.M., the Administrator provided an undated Reporting Direct Care Staffing Information (Payroll-Based Journal) policy which indicated "...9. Direct care staffing is submitted on the schedule specified by CMS, but no less frequently than quarterly. 10. Staffing information is collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter..."		*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. The facility administrator will now be responsible and is submitting the PBJ information in accordance with the CMS schedule. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the facility executive director on the facility policy related to the submission of the PBJ information to CMS in accordance with their established schedule. The facility Executive Director will now be responsible for the submission of this information to CMS. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor compliance with the submission of the PBJ information to CMS. This tool will be completed quarterly by the Clinical Director of Operations. The completion of this tool will be on-going in conjunction with the CMS schedule.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control			

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	The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or 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,			

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	depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to maintain an infection prevention program for 1 of 2 residents reviewed for infections, 1 random observation, and 2 of 2 halls reviewed for water system management. Proper PPE (personal protective equipment) was not used to care for a resident with MRSA (Methicillin Resistant Staph Aureus-a skin infection), an uncovered catheter bag was dragging on the floor, and there was no program for monitoring the water system for the growth of	F 0880	F - 880 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 16 now has an order for contact precautions related to their current infections. Resident 16 also now has a care plan to address the use of contact precautions related to wound	04/12/2024

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	Legionella (bacteria). (Resident 16, Resident 29, East Hall, West Hall) Findings include: 1. On 3/11/24 at 1:12 P.M., Resident 16's clinical record was reviewed. Diagnoses included, but were not limited to, MDRO (Multidrug-resistant bacteria) and diabetes mellitus. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 11/24/23, indicated Resident 16 had severe cognitive impairment. Progress nursing notes included the following: 2/23/24 at 2:07 P.M., "...Late Entry: Note Text: Please obtain wound culture." 2/26/24 at 12:41 P.M., "...Wound cultures results forwarded to MD [medical doctor]. Awaiting response." A Lab Results Report indicated the following: Collection Date: 2/23/24 6:59 A.M. Received Date: 2/23/24 9:39 A.M. Reported Date: 2/27/24 10:59 A.M. Specimen description: foot Organism: MRSA Reviewed by the ADON (Assistant Director of Nursing) on 2/28/24 at 8:41 A.M. Resident 16's clinical record lacked a current order for MRSA and contact precautions. Resident 16's clinical record lacked a care plan for MRSA and contact precautions. During an interview on 3/12/24 at 12:27 P.M., the DON (Director of Nursing) indicated that Resident 16 did not currently have MRSA. During an interview on 3/12/24 at 12:40 P.M., the		infection. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 29 now has their foley catheter drainage bag and tubing securely positioned and is not touching the floor. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now had the water supply/system checked related to Legionella surveillance. No issues were identified. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by the deficient practice. A housewide audit of all residents has been conducted to identify any infectious processes and to ensure all necessary infection control practices are in place. No additional issues were identified. A housewide audit was also conducted on those residents with urinary catheters to ensure that the position of the catheter drainage bags and tubings were properly secured up off to floor.	

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	MDS Coordinator indicated Resident 16 had a MRSA positive wound culture on 2/23/24 and should have an order and care plans for MRSA and contact precautions. During an observation on 3/12/24 1:07 P.M., Resident 16 was laying in bed. At that time, he indicated he had wounds to both feet. The facility failed to have any notification that the resident was on contact precautions on the door. During an interview on 3/13/24 at 8:57 A.M., LPN (Licensed Practical Nurse) 5 indicated he was unsure if Resident 16 had MRSA and needed to check if he should be on contact precaution. During an interview on 3/13/24 at 9:21 A.M., the Wound Nurse indicated she was not aware that Resident 16 had MRSA. She indicated staff did not utilize contact precautions prior to 3/13/24. During an observation on 3/13/24 at 9:29 A.M., the Wound Nurse and ADON brought a cart full of isolation items and contact precaution sinage for the door. At that time, the ADON indicated no other residents in the building had MRSA. During an interview on 3/13/24 at 9:43 A.M., the ADON indicated when a culture comes back positive for MRSA, the nurse should contact the Wound Nurse and MD to obtain orders for MRSA and contact precautions. During an interview on 3/13/24 at 1:41 P.M., the ADON indicated it was the facilities policy to initiate an order and implement a care plan for MRSA and contact isolation when a positive result was obtained. 2. On 3/4/24 at 12:09 P.M., Resident 29 was observed being wheeled into the dining room by		No additional issues were identified. The facility has also conducted a testing of the facility's water system and no issues were identified. The facility will continue to conduct annual testing or more often if warranted. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's infection prevention and control policies and procedures. The in-service also reviewed the facility's isolation policies and procedures to ensure the knowledge level of the staff on the proper infection control practices (PPE equipment) that were to be utilized when an infection has been identified. The facility also reviewed the policy and procedures to be followed for those residents with a urinary catheter in an effort to prevent infections. The in-service also included a review of the facility's Legionella Surveillance and Detection policy. F – 880 (continued) *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been	

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	the Director of Nursing (DON). Catheter bag tubing was observed to be dragging the floor under the resident's wheelchair. 3. During an interview on 3/11/24 at 10:14 A.M., the Maintenance Supervisor indicated (name of company) came and did water testing. He was unsure how often, possibly yearly. At that time, he indicated there was no plan for monitoring Legionella development and not sure if they had any prevention practices, but he would check with the Administrator to be sure. On 3/11/24 AT 10:16 A.M., the last water testing report was requested and not provided during the survey period. During an interview on 3/12/24 at 1:00 P.M., the Administrator indicated she was unaware of any Legionella prevention and testing programs. On 3/13/24 at 8:50 A.M., a current nondated Legionella Water Management Program Policy was requested and provided by the Administrator and indicated "Our facility is committed to the prevention, detection, and control of water-borne contaminants, including Legionella ... As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team ...The purpose of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease ... " On 3/14/24 at 9:22 A.M., the ADON provided an undated Contact Precautions sign from the CDC (Centers for Disease Control and Prevention) that indicated, "...PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry...Put on gown before room entry...Use dedicated or		developed and implemented to monitor the effectiveness of the facility's infection prevention and control program. The tool will monitor to ensure that all identified infectious processes are being treated in accordance with facility's infection control policy with appropriate personal protective equipment being utilized as warranted. The tool will also monitor the proper handling of urinary drainage bags/tubings in attempt to prevent infections and the tool will also monitor to ensure that the facility water system is being tested in accordance with the regulation. This tool will be completed by the Infection Control Preventionist and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155508	A. BUILDING 00 B. WING	03/14/2024

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	disposable equipment..." 3.1-18(b)(2)			
F 0919 SS=D Bldg. 00	483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. Based on observation, interview, and record review, the facility failed to ensure resident's call lights were properly functioning and in reach for 3 of 21 residents reviewed in the sample. Call lights were on the floor, out of reach for the resident and not functioning. (Resident 46, Resident 203, Resident E, Room 37) Findings include: 1. During an observation on 3/4/24 at 12:23 P.M., Resident 46 was in bed, and her call light was on the floor. CNA (Certified Nurse Aide) 18 walked by the call light to drop off a meal tray and failed to pick the call light up and place it in the resident's reach. During an observation on 3/5/24 at 9:10 A.M., Resident 46 was observed in bed and her call light was on the floor. During an observation on 3/6/24 at 8:38 A.M., LPN (Licensed Practical Nurse) 21 administered medication to Resident 46. At that time, Resident 46's call light was on the floor and LPN 21 failed to	F 0919	F - 919 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 46 now has their call light within reach at all times. The staff members identified as CNA 18 and LPN 21 have been re-educated on their responsibility for ensuring that the resident has their call light within reach upon each resident contact. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident E now has their call light within reach at all times. The staff member identified as CNA 7 was re-educated on the proper placement of the resident's call light to ensure that the call light was within the resident's reach and not hanging down at the	04/12/2024

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	place it in reach of the resident. During an observation on 3/6/24 at 8:57 A.M., LPN 21 walked by Resident 46 and failed to pick the call light up off of the floor. On 3/7/24 at 10:23 A.M., Resident 46's clinical record was reviewed. Diagnoses included, but were not limited to, non-Alzheimer's dementia and depression. The most recent Quarterly MDS (minimum data set) Assessment indicated resident 46 had severe cognitive impairment and required an extensive assist of 1 staff member for bed mobility, transfers, eating, and toileting. During an interview on 3/7/24 at 10:09 A.M., the DON (Director of Nursing) indicated Resident 46 is capable of using her call light. During an interview on 3/12/24 at 10:46 A.M., RN (Registered Nurse) 9 indicated all resident's should have their call light in reach, and if the call light is on the floor, it should be picked up and given to the resident. 2. On 3/8/24 at 9:40 A.M., Resident E was observed in bed eating breakfast with the call light wrapped around the right bed rail and hanging down. On 3/11/24 at 9:10 A.M., Resident E was sitting in her wheelchair in her room by the wall across from her bed and the call light was wrapped around the resident's right bed rail. On 3/6/24 at 10:58 A.M., Resident E's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, dysphagia, stroke, right side hemiplegia (paralysis of one side of the body).		side of resident E's bedrail. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 203 now has their call light within reach at all times. The staff member identified as CNA 3 has been re-educated on their responsibility for ensuring that the resident has their call light within reach upon each resident contact. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* no specific resident was identified during the survey. The call light in the bathroom of room 37 has now been repaired and is functioning properly. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all call light pull stations has been conducted. All call light pull stations are now functioning properly. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing, housekeeping/laundry and maintenance staff on the facility's call light policy. All staff members	

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	The most recent Quarterly MDS Assessment, dated 2/16/24, indicated Resident E's cognition was moderately impaired, was totally dependent on 2 staff for bed mobility, transfers, toileting, and an extensive assist of 1 staff for eating. A current Fall Risk Care Plan, revised 9/8/23, included, but was not limited to the following interventions: "Be sure call light is within reach and encourage her to use it for assistance as needed", initiated 8/17/23 During an interview on 3/8/24 at 9:46 A.M., Certified Nurse Aide (CNA) 7 indicated all residents with rooms to the right of the West Hall Nurse's Station (when looking at the nurse's station) could use the call light and she had set up the breakfast tray for Resident E that morning and had been in the room twice to see if she was finished eating. At that time, CNA 7 observed the call light wrapped around the right bed rail and hanging down. When Resident E was asked to press her call light, the resident reached across her body with her left hand 3 times and was not able to reach her call light. CNA 7 indicated the resident wanted the call light on her right side bed rail because it was easier to reach across her body with the left hand then reach backwards with her left hand when she was in her bed. CNA 7 then unlooped the call light cord once and pointed the call light towards the resident instead of hanging downwards and the resident was able to press the call light at that time. 3. On 3/4/24 at 9:48 A.M., Resident 203 was observed laying in bed trying to open a container of cereal, coffee was spilt in her tray, call light was on the floor hanging from the left side of bed, and		were re-educated on their responsibility to ensure that each resident has their call light within reach with each resident contact. The staff was also reminded of their responsibility for promptly reporting any malfunctions of a call light to the maintenance director for prompt repair. F – 919 (continued) *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the placement and functioning of resident's call lights. The tool will monitor to ensure that resident's call lights are within reach of the resident at all times. This tool will be completed by the Social Service Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	Resident 203 indicated "I'm not sure where my call light went". On 3/4/24 at 9:57 A.M., CNA 3 was observed at the West Hall Nurse's Station on her cell phone and was asked to help open the cereal container for Resident 203. CNA 3 went into Resident 203's room. On 3/4/24 at 10:00 A.M., CNA 3 was observed returning back to the West Hall Nurse's Station from Resident 203's room, sitting down, and picking up her cell phone. On 3/4/24 at 10:02 A.M., Resident 203 was observed laying in bed eating cereal from the opened container, coffee was still spilt in her tray, and the call light was still on the floor hanging from the left side of bed. On 3/8/24 at 7:45 A.M., Resident 203 was observed laying in bed asleep and her call light was on the floor hanging from the left side of her bed. On 3/5/24 at 12:56 P.M., Resident 203's clinical record was reviewed. Diagnoses included, but were not limited to, multiple sclerosis. The most recent Quarterly MDS Assessment, dated 1/29/24, indicated Resident 203 was cognitively intact and an extensive assist of 2 staff for bed mobility, totally dependent on 2 staff for transfers and toileting, an extensive assist of 1 staff for eating. A current Fall Risk Care Plan, revised on 1/30/23, included, but was not limited to, the following interventions: "Keep frequently used personal items including			

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	call light within reach, initiated 10/7/22 During an interview on 3/11/24 at 10:05 A.M., the ADON indicated resident's call light should be within reach of resident. During an interview on 3/8/24 at 9:38 A.M., Licensed Practical Nurse (LPN) 14 indicated all residents with rooms to the right of the West Hall Nurse's Station (when looking at the nurse's station) could use a call light and they should always be within reach of resident. 4.On 3/5/24 at 10:37 A.M., the call light in Room 37's bathroom did not work. On 3/14/24 at 9:10 A.M., the call light in Room 37's bathroom did not work. During an interview on 3/14/24 at 10:32 A.M., the Maintenance Supervisor indicated he was unaware of the call lights not working and staff or residents should tell him about the call lights malfunctioning and fill out work orders that go in the copy room. He checks the copy room every morning. On 3/11/24 at 10:55 A.M., a nondated current Call Light Answering Policy was provided by the Administrator and indicated " ... 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, form the shower or bathing facility and from the floor." 3.1-38(a)(2)(E) 3.1-19(u)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions			

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	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 2 of 2 resident halls, 2 of 2 shower rooms, and 1 of 2 nurses stations. (East Hall, East Hall nurses station, West Hall) Findings include: 1. On 3/5/24 at 10:34 A.M., the West Hall shower room was observed with debris on the floor, the floor was observed to be sticky, a candy bar wrapper was on the floor with ants crawling around it, and a tissue, used glove, and four alcohol prep packages were observed on the floor. A used paper towel was observed on the top of the trashcan lid. The shower chair had a brown substance smeared in the seat. The area of the floor tile where it met the wall was observed with a black substance, and the ceiling had chipped paint. On 3/5/24 at 1:25 P.M., the West Hall shower room was observed the same, with an alcohol wipe on the floor of the shower area. On 3/14/24 at 9:18 A.M., the West Hall shower room was observed freshly mopped. The trashcan was missing a bag, and the call light cord was dragging the floor. The ceiling vent was caked with dust, and the shower chair had a brown substance still smeared on the seat. The area of the floor tile where it met the wall was observed with a black substance, and the ceiling had chipped paint. Two alcohol pads were observed on the floor of the shower area.	F 0921	F - 921 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents and staff on the West Hall have the potential to be affected by this deficient practice. The West Hall shower room has now been deep cleaned and repairs made. All debris has been removed from the floor. The floor has been moped and is no longer sticky. The shower chair has been thoroughly cleaned and is free of any brown substance. The area of the floor tile where it meets the wall has been scrubbed and no longer has any black substance present. The West Hall shower room ceiling has been re-painted and no longer has chipped paint. The trash can container has a trash bag in it. The call light pull cord has been shortened and no longer drags the floor. The ceiling vent has been cleaned and no longer contains any dust. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the scuff marks on the wall under the window in room 41 have now been removed. The broken window blind in room 41	04/12/2024

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	2. On 3/5/24 at 10:40 A.M., Room 41 was observed with scuff marks on the wall under the window and two broken blinds. The bathroom was observed with a plastic lid and straw inside of a bedpan sitting on the floor in a trashbag, brown smudges were observed on the raised toilet seat, three wash basins were observed on top of the toilet tank uncovered, and paint was observed peeling from the wall around the sink. On 3/14/24 at 9:08 A.M., Room 41 was observed the same except the toilet tank was empty, and two uncovered wash basins were observed on the floor of the bathroom. 3. On 3/5/24 at 10:29 A.M., Room 36's bathroom was observed with no stopper in the sink, a brown smudge on the back of the toilet tank, no trashbag in the trashcan with a soiled incontinence brief. A crack was observed in the floor in front of the air unit and paint was observed bubbling up on one side of the unit. The top of the wall was cracked with paint chipping, no trashbag in the trashcan in the room, and an outlet box was observed not sitting flush with the wall by the television. On 3/14/24 at 9:14 A.M., Room 36's bathroom was observed with no stopper in the sink, a crack was observed in the floor in front of the air unit and paint was observed bubbling up on one side of the unit, and an outlet box was observed not sitting flush with the wall by the television. 4. On 3/5/24 at 10:29 A.M., a dip was observed in the floor in front of Room 35. On 3/14/24 at 9:11 A.M., the same was observed. 5. On 3/5/24 at 10:44 A.M., Room 44 was observed		has been replaced. The items identified on the floor and on the back of the toilet tank in the bathroom or room 41 have been removed. The raised toilet seat in the bathroom of room 41 has been cleaned and is free of any brown smudges. The walls of the bathroom in room 41 have been painted and are now free of peeling paint. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the bathroom in room 36 has been cleaned. There is no longer a brown smudge on the back of the toilet tank. The bathroom sink has been repaired and now has a stopper in the sink. The crack in the floor in front of the air unit has been repaired. The bubble up paint has been removed and the area re-painted. The top of the wall that was cracked has been repaired and re-painted. There is now a trash bag in the trashcan in the room. The outlet by the television is now fitting flush with the wall. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the dip in the floor in front of room 35 has now been repaired. *5.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the used clothes in	

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	155508	A. BUILDING 00 B. WING	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF BOONVILLE	725 S SECOND ST BOONVILLE, IN 47601

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	with used clothes in the sink, dust caked in the exhaust fan on the ceiling, caulk cracking around the sink, and scuffs on the bottom of the door with the top layer peeled off. On 3/14/24 at 9:06 A.M. Room 44 was observed with dust caked in the exhaust fan on the ceiling, caulk cracking around the sink, and scuffs on the bottom of the door with the top layer peeled off. 6. On 3/5/24 at 10:47 A.M., Room 39 was observed with a fly trap hanging by the ceiling in the corner with dead flies on it. The paper was yellowed and brown. The resident in the room indicated the fly trap had been hanging in the room for a year. On 3/14/24 at 9:12 A.M., Housekeeper 12 indicated housekeeping staff cleaned rooms once a day. Shower rooms were cleaned daily. She indicated normally there were three housekeepers in the facility. She indicated if anything broken was noticed, staff should write it down, fill out a sheet, and put it in the copier room for the maintenance man. 7. On 3/13/24 at 2:07 P.M., Room 21's bathroom was observed to have multiple, small pieces of debris on the bathroom floor. 8. On 3/13/24 at 2:14 P.M., Room 25 was observed to have multiple small pieces of paper and debris on the floor in the doorway and in the hallway outside of the room. On 3/14/24 at 11:44 A.M., the Maintenance and Housekeeping supervisor was notified of the findings in both rooms. 9. On 3/4/24 at 9:15 A.M., a brown substance was observed around the bottom rim of the toilet in between rooms 43 and 45.		the sink of room 44 have now been removed. The exhaust fan in the ceiling of room 44 has been cleaned and is now free of dust. The cracked caulking around the sink has been replaced. The door of room 44 has now been repaired and is in good condition. *6.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the fly trap hanging from the ceiling in room 39 has now been removed. *7.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the bathroom floor of room 21 has now been cleaned and is free of debris. F - 921 (continued) *8.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the floor of room 25 has now been cleaned and is free of debris and small pieces of paper. *9.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the toilet located in the bathroom between rooms 43 and 45 has now been cleaned and there is no longer a brown substance at the bottom rim of the toilet. *10.) The corrective action taken for those residents found to have*	

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	The same was observed on 3/14/24 at 9:05 A.M. 10. On 3/5/24 at 10:51 A.M., the flooring in the hallway by room 5 had a visible gap. When stepped on, the floor sunk and dipped below the baseboard. The same was observed on 3/14/24 at 8:59 A.M. 11. On 3/5/24 at 10:53 A.M., the shower room on the East hall was observed with the following: 2 tiles loose on the right side and resting on the floor with bare flooring underneath 2 tiles on the left side that were chipped bottom around the wall was brown and discolored around the whole room 3 of 3 call lights failed to work 1 of 3 call light boxes was resting on the floor with exposed wires coming out of the wall the bottom of the toilet paper holder had a brown substance around it the paper towel holder was sideways and loose the door to the air conditioner unit was not attached and hung down caulk around the air conditioner unit was cracked and coming up the back of the door to leave the shower room was scuffed and had paint peeled off the ceiling had paint peeled off the exhaust fan had a layer of gray debris on it the shower chair had one leg shorter than the other leg On 3/14/24 at 8:54 A.M., the shower room on the East hall was observed with the following: 3 tiles loose on the right side and resting on the floor with bare flooring underneath 2 tiles on the left side that were chipped bottom around the wall was brown and discolored around the whole room		*been affected by the deficient practice is that* the flooring in the hallway by room 5 has now been repaired and no longer has a visible gap. *11.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the shower room on the East Hall has now had the broken and missing floor tiles replaced. All three call light boxes have been repaired and are now functioning properly. The toilet paper holder has now been cleaned and is free of any brown substance. The paper towel holder has now been repaired and fits securely on the wall. The door to the air conditioning unit has been repaired and now is secure. The caulking around the air conditioning unit has been replaced. The shower room door has now been repaired and is free of peeling paint. The shower room ceiling has been re-painted and is now free of peeling paint. The exhaust fan has now been cleaned and is free of debris. The shower chair with the uneven legs has now been replaced. *12.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the countertop of the front nurses' desk has now been repaired and no longer has exposed wood. *13.) The corrective action taken*	

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	155508	A. BUILDING 00 B. WING	03/14/2024

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	3 of 3 call lights failed to work the bottom of the toilet paper holder had a brown substance around it the paper towel holder was sideways and loose the door to the air conditioner unit was not attached and hung down caulk around the air conditioner unit was cracked and coming up the back of the door to leave the shower room was scuffed and had paint peeled off the ceiling had paint peeled off the exhaust fan had a layer of gray debris on it the shower chair had one leg shorter than the other leg 12. On 3/6/24 at 10:32 A.M., the nurses desk in the front of the building was observed to have exposed wood where the countertop peeled off The same was observed on 3/14/24 at 9:00 A.M.13. On 3/4/24 at 10:13 A.M., room 49 was observed. The entrance door was hard to open. It had a strong urine and smoke odor, the bedside table was covered with a sticky substance, the window blinds were broken, the air conditioner cover was off and leaning against it. The private bathroom had brown feces on the floor, cracked and brown caulk around the toilet, a red splatter on the floor by the sink, loose vent hanging from the ceiling, and there were brown splatters on the outside of the toilet bowl. Outside the bathroom door, it felt like there was a hole under the carpet. On 3/14/24 at 10:18 A.M., room 49 was observed. The entrance door was still hard to open, the air conditioner cover was off and leaning against it, had a strong urine odor, broken window blinds. The private bathroom still had a loose vent hanging down, brown and cracked caulk around the toilet, and there were brown splatters on the		*for those residents found to have been affected by the deficient practice is that* the door to room 39 has now been repaired and opens smoothly. Room 39 has not been deep cleaned and is free of odors or any sticky substance on the bedside table. The broken window blinds have now been replaced. The cover to the air conditioning unit has been repaired and is properly fitted over the air conditioning unit. The bathroom to room 39 has now been deep cleaned. The bathroom floor has been cleaned and is free of any debris. The caulking around the toilet has now been replaced. The loose ceiling vent has been cleaned and secured to the ceiling. The flooring outside of the bathroom door has now been repaired. *14.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the entrance door to room 51 has now been repaired and is free of any splitting wood. The air conditioner cover has now been re-painted. The door stop has now been repaired. F - 921 (continued) *15.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the foot board of the bed for the resident identified as resident 30 has now been	

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	155508	A. BUILDING 00 B. WING	03/14/2024

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	outside of the toilet bowl. Outside the bathroom door, it felt like there was a hole under the carpet. 14. On 3/4/24 at 12:25 P.M., room 51 was observed. The entrance door wood was splitting at the bottom, the paint on the air conditioner was scratched and scoffed up, and the door stop was laying on floor by the bathroom. On 3/14/24 at 10:23 A.M., the same was observed. 15. On 3/4/24 at 12:26 P.M., room 52 was observed. The foot board of Resident 30's bed on the right side was broken off. In the bathroom, shared with room 54, there was a brown substance smeared on the floor, door, on the door frame next to the sink, and the sink. There was a soaked paper towel next to toilet and brownish colored liquid leaking from around the toilet. On 3/14/24 at 10:24 A.M., room 52 was observed. The footboard of the bed was the same, and there was still brown substance smeared on the door and on the door frame next to the sink. A brownish colored liquid was leaking from around the toilet. 16. On 3/04/24 at 10:27 A.M., the West Hall floor outside room 46 felt like the carpet was covering a hole. It was uneven down the middle of the hall, the air conditioner unit cover, across from room 50, was sticking out on the bottom. There was a rip in the carpet in the middle of the hall in front of the first air conditioner unit on the left and the carpet was loose. The dining room floor was sticky and there was food debris scattered throughout the dining room. Baseboard was coming off the wall under the big clock in the West Hall. On 3/14/24 at 10:12 A.M., the same was observed. On 3/4/24 at 12:07 P.M., the Maintenance		replaced. The floors, door, door frames and sink of the bathroom shared between rooms 52 and room 54 have now been cleaned and are free of any brown substance. The toilet has been repaired and no longer leaks. *16.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the flooring outside room 46 has now been repaired. The hall air conditioning cover located across the hall from room 50 has been repaired and now fits securely over the air conditioning unit. The carpeting in the middle of the hall of the West unit has been repaired and is now secure. The dining room floor has now been cleaned and is free of debris or any sticky substance. The baseboard under the big clock in the West Hall has been repaired and now fits securely to the wall. *17.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the laundry/trash bin located on the right side of the West Hall has now been cleaned and is free of any brown substance. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. A housewide	

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	Supervisor was observed stopping at the rip in the carpet in the middle of hall in front of the first air conditioner unit on the left, stepped on it with his left foot a couple times, and then continued walking past. 17. On 3/11/24 at 9:00 A.M., a laundry/trash bin against the right wall in the West Hall was observed with a brown substance smeared and brown splotches covering the top lids and on sides of the PVC pipe stand. On 3/13/24 at 12:50 P.M., a current Maintenance/Housekeeping Policy, revised 9/22/14, was provided by the Assistant Director of Nursing (ADON) and indicated "It is the policy of Transcendent Healthcare to assure that the building is comfortable and clean in accordance with the regulation ... The Housekeeping cleaning schedule is to be followed which includes daily cleaning of resident rooms ... each resident bathroom is to be cleaned a minimum of daily or more frequently if directed ... floors throughout the building are to be cleaned in accordance with the cleaning schedule " On 3/13/24 at 12:50 P.M., an Environmental Services/ Maintenance policy, revised 4/13/17, indicated, "...a. To assist in maintaining a standard of excellence, our Environmental Services department has developed a quality control program that provides a safe, functional, sanitary, and comfortable environment for residents, staff and the public in accordance with regulations..." 3.1-19(f) 3.1-19(f)(5)		audit of all areas of the facility has been completed and a list has been developed of any housekeeping or environmental issues that were identified throughout the facility. All areas identified in need or cleaning, repair or replacement have now been corrected. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's policies and procedures related to maintaining a clean, safe, sanitary and comfortable environment. All staff members were re-educated on their specific responsibilities to ensure that the environment was kept clean, safe and in good condition to maintain a home-like atmosphere for the residents. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the environment of the facility. The tool will monitor for cleanliness/sanitation, furniture/equipment in good functioning condition and identify any environmental concerns that need prompt attention. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then	

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			quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 9999 Bldg. 00		F 9999	9999	04/12/2024
	3.1-13 Administration and management (m) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under a written agreement. Such agreements pertaining to services furnished by outside resources must specify, in writing, that the facility assumes responsibility for the following: (1) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility. This State rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure the beautician's license was current. (Facility) Finding includes: On 3/12/24 at 9:22 A.M., during review of employee files the beautician's license was observed to have expired on 8/1/22.		*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents have the potential to be affected by this deficient practice. The facility's contracted beautician now has a current license on file. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. The facility's contracted beautician now has a current license on file. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the Business Office Manager, Executive Director, Director of Rehab Services and the Director of Nursing on their responsibility to ensure that their respective staff	

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	During on interview on 3/12/24 at 9:22 A.M., the ADON (Assistant Director of Nursing) provided a copy of the beautician's license and indicated the license expired in 2022. She indicated the license was pulled due to back taxes and that the beautician was going to pay the taxes today to get her license back. She indicated the license should be current. At that time, a paper was provided with a list of dates of service the beautician was in the facility which included 12/22/23, 1/5/24, 2/2/24, 2/9/24, 2/16/24, 2/23/24 and 3/8/24. During an interview on 3/13/24 at 1:28 P.M., the Business Office Manager indicated the beautician was a contracted employee.		members maintain all required licensures and/or certifications as required. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor employee files to ensure each employee that is required to maintain a licensure and/or certification has a valid license/certification on file. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	