STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLINTON HOUSE REHABILITATION AND HEALTHCARE CENTE	809 W FREEMAN ST FRANKFORT, IN 46041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit also included the Investigation of Complaints IN00439641, IN00440622 and IN00441593. Complaint IN00439641 - No deficiencies related to the allegations are cited. Complaint IN00440622 - No deficiencies related to the allegations are cited. Complaint IN00441593 - Federal/state deficiencies related to the allegations are cited at F804. Survey dates: Septermber 3, 4, 5, 6, 9 and 10, 2024. Facility number: 000192 Provider number: 155295 AIM number: 100291120 Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 8 Medicaid: 59 Other: 14 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on September 19, 2024.	F 0000	10-3-2024 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 CCN/Provider Number 155295 AIM Number 100291120 Facility ID 000192 Event ID 5Q4L11 Re: Recertification and State Licensure with Complaint Survey Clinton House Rehabilitation and Healthcare Center 809 West Freeman St Frankfort, IN 46041-2994 Dear Ms. Buroker: On September 10, 2024, a Recertification and State Licensure with Complaint (IN00439641, IN0044062, IN00441593) Survey was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiencies. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Goran Prentoski	HFA	09/26/2024

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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			review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of October 3, 2024 Please feel free to call me with any further questions at 765-654-8783. Respectfully submitted, Goran Prentoski Executive Director	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan Based on observation, interview and record review, the facility failed to ensure baseline care plans were completed within 48 hours after admission for 2 of 2 residents reviewed for baseline care plans. (Resident B and 34) Findings include: 1. During an observation, on 9/3/24 at 10:51 a.m., Resident B was wearing oxygen at 3 liters. The clinical record for Resident B was reviewed on 9/5/24 at 1:25 p.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure, type 2 diabetes, stage 3 chronic kidney disease, obstructive sleep apnea, and retention of urine. The resident was admitted on 8/29/24. While reviewing the resident's care plan, the resident did not have a baseline care plan for the use of oxygen.	F 0655	F655 D Develop/ Baseline Care Plan The facility requests paper compliance for this citation This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for	10/03/2024

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	During an interview, on 9/6/24 at 2:31 p.m., the Chief Nursing Officer (CNO) indicated there was not a respiratory baseline care plan for the resident. The policy was for the baseline care plan to be started within 48 hours of admission.2. The clinical record for Resident 34 was reviewed on 9/4/24 at 2:39 p.m. The diagnoses included, but not limited to, pneumonia, acute on chronic systolic congestive heart failure, major depressive disorder, chronic kidney disease stage 3, and anxiety disorder. The resident's initial admission date was 7/18/24. The baseline care plan meeting date was recorded as occurring on 7/22/24 at 10:30 a.m. The resident was discharged to the hospital on 7/23/24. The resident was readmitted to the facility again on 7/27/24. The clinical record did not include a new baseline care plan meeting. During an interview, on 9/6/24 at 2:05 p.m., the Social Services Director indicated the baseline care plan meetings were recorded in the clinical record. A current facility policy, titled "Baseline Care Plan," dated 10/20/23 and received from the Interim Executive Director on 9/6/24 at 2:40 p.m., indicated "...Upon admission, the admission nurse will initiate the development of the baseline care plan as part of the admission assessment. The baseline care plan will continue to be developed by the interdisciplinary team and be completed within 48 hours of admission." 3.1-35(a)		those residents identified: • Identified resident #B no longer resides in facility. Resident #34 were assessed and care plans reviewed and revised for accuracy. 2) How the facility identified other residents: • An audit was conducted for those new residents admitted to the facility within last 30 days to determine baseline care plans were completed. • Any identified issues were corrected. • Care plans are initiated/reviewed upon admission-admission, annually, quarterly, for significant change and as needed. • Baseline care plans will be reviewed within 48 hours of admission. • Care plans are additionally reviewed and updated during scheduled care plan meetings. 3) Measures put into place/ System changes: • In-service conducted with the interdisciplinary team to review procedures for development of baseline care plans and comprehensive care plan. • New admission baseline care plans will be reviewed within 48 hours of admission. • Resident care plans will be reviewed/updated on admission, readmission, change of condition, quarterly and annually, with significant change and as needed.	

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			4) How the corrective actions will be monitored: • The Director of Nursing and MDS Coordinator will randomly review three residents 'admission records weekly ensuring that baseline care plans have been developed that accurately reflect resident status. • MDS coordinator will review during scheduled care plan meetings to ensure care plans are reflective of resident's status. • Any issues identified will be immediately addressed. • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. 5) Date of compliance: • 10-3-2024	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to administer an as needed medication for weight gain, to notify the physician of a weight gain and to hold insulin doses per the physician's orders for 2 of 2 residents reviewed for quality of care. (Resident 34 and 68) Findings include: 1. The clinical record for Resident 34 was reviewed on 9/4/24 at 2:39 p.m. The diagnoses included, but were not limited to, pneumonia, acute respiratory	F 0684	F 684 D Quality of Care The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of	10/03/2024

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	failure with hypoxia (absence of enough oxygen to sustain bodily functions), acute on chronic systolic congestive heart failure (heart is unable to pump blood as well as it should), and chronic kidney disease stage 3. A physician's order, dated 7/28/24, indicated to weigh the resident daily and to notify the physician if the resident had a weight gain of 3 pounds in a day or 5 pounds in a week for congestive heart failure. A physician's order, dated 7/28/24, indicated to give furosemide (a diuretic medication) 40 milligrams (mg) by mouth every 24 hours as needed (PRN) for a greater than 3-pound weight gain. The vitals record in the electronic medical record indicated the resident's weights included, but were not limited to, a. On 8/4/24, the weight was 152 pounds and on 8/5/24 the weight was 155.5 pounds. This was a documented increase of 3.5 pounds in a day. b. On 8/10/24, the weight was 149.9 pounds and on 8/16/24 the weight was 161 pounds. This was a gain of 11.1 pounds in a week. c. On 8/11/24, the weight was 150 pounds and on 8/12/24 the weight was 156.5 pounds. This was an increase of 6.5 pounds in a day d. On 8/13/24, the weight was 156.5 pounds and on 8/14/24 the weight was 162 pounds. This was a gain of 5.5 pounds in a day. e. On 8/28/24, the weight was 158.5 pounds and on 8/30/24 the weight was 162 pounds. There was no weight found for 8/29/24. This was a gain of 3.5 pounds. The vitals record had multiple dates of missing weights.		deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.) Immediate actions taken for those residents identified: • Residents #34 weight was reported to physician and #68 had insulin orders reviewed with primary care physician, assessment completed, and care plans updated. 2) How the facility identified other residents: • Any resident residing in the facility receiving insulin or had a weight concern had the potential to be affected. • Facility audit was conducted by Director of Nursing/Designee to review current resident weights and insulin orders and reviewed with primary care physician • Medication administration records were reviewed for the past 30 days to determine medications had been administered per physician order. • Any new identified issues were reported to the primary physician for review. 3) Measures put into place/ System changes: • Licensed Nursing staff and QMA and C.N.A's were educated on: 1. Notification of Physician of change in condition 2. Facility protocol on weighing residents	

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	The Medication Administration Record (MAR), dated 8/1/24 through 8/31/24, indicated there had been no administrations of the furosemide PRN dose for a weight gain greater than 3 pounds. The electronic medical record did not indicate the physician had been notified of any weight gain greater than 3 pounds in a day or greater than 5 pounds in a week. During an interview, on 9/3/24 at 12:15 p.m., the resident indicated her main issue was with her breathing and feeling short of breath. She indicated the oxygen, and breathing treatments did not take away her discomfort of feeling short of breath on some days. The resident indicated her legs hurt more when they were more swollen. During an interview, on 9/6/24 at 2:25 p.m., the Director of Nursing (DON) indicated there had been no PRN furosemide doses documented as being given with the weight gain of greater than 3 pounds. She also indicated the provider had not been notified of weight gains as it occurred. 2. The clinical record for Resident 68 was reviewed on 9/6/24 at 1:32 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, type 2 diabetes mellitus with hyperglycemia and diabetic neuropathy, Parkinson's disease, gastroparesis, vascular dementia with mood disturbance, mild cognitive impairment, long term current use of insulin, depression, anxiety disorder, visual hallucinations, and tremor. A physician's order, dated 3/11/24 and discontinued 6/9/24, indicated to inject 28 units of		3. Following physician orders with specific focus on insulin administration. 4) How the corrective actions will be monitored: • Director of Nursing is the responsible party for this Plan of Correction with Executive Director oversight. • Review of 24-hour report daily during clinical morning meeting per Director of Nursing/ IDT to identify change of conditions and physician notification. • Review of resident weights weekly during scheduled Nutrition at risk meeting, per Director of Nursing/designee and registered dietician • Review of 3 residents insulin administration records weekly for accuracy. • Identification of concerns will be addressed immediately • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5.) Date of compliance: • 10-3-2024	

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	insulin glargine-yfgn subcutaneously two times a day for diabetes and to hold if the blood glucose was less than 200. A physician's order, dated 6/9/24, indicated to inject 34 units of insulin glargine-yfgn subcutaneously two times a day for diabetes and to hold if the blood glucose was less than 200. A MAR, dated 6/1/24 through 6/30/24, indicated insulin glargine-yfgn 34 units was given with a documented blood glucose level less than 200 on 6/2/24 for the a.m. and p.m. doses, 6/4/24 for the a.m. dose, 6/7/24 for the p.m. dose, 6/11/24 for the a.m. dose, 6/13/24 for the a.m. and p.m. doses, 6/13/24 for the a.m. and p.m. doses, 6/14/24 for the a.m. dose, 6/16/24 for the a.m. dose, 6/18/24 for the a.m. dose, 6/21/24 for the p.m. dose, 6/22/24 for the a.m. dose, 6/28/24 for a.m. dose, and 6/30/24 for the a.m. dose. The documented blood glucose range was 115 to 197 for the doses given against the order to hold for a blood glucose less than 200. A MAR, dated 7/1/24 through 7/31/24, indicated insulin glargine-yfgn 34 units was given with a documented blood glucose level less than 200 on 7/4/24 for the a.m. and p.m. doses, 7/5/24 for the a.m. dose, 7/6/24 for the a.m. dose, 7/8/24 for the a.m. dose, 7/9/24 for the a.m. dose, 7/13/24 for the a.m. and p.m. doses, 7/14/24 for the a.m. dose, 7/16/24 for the a.m. dose, 7/17/24 for the a.m. dose, 7/20/24 for the a.m. and p.m. doses, 7/22/24 for the a.m. dose, 7/23/24 for the a.m. dose, 7/28/24 for the a.m. dose, and on 7/30/24 for the a.m. dose. The documented blood glucose range was 107 to 197 for the doses given against the order to hold for a blood glucose less than 200. A MAR, dated 8/1/24 through 8/31/24, indicated			

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	insulin glargine-yfgn 34 units was given with a documented blood glucose level less than 200 on 8/2/24 for the a.m. dose, 8/4/24 for the a.m. dose, 8/5/24 for the a.m. dose, 8/8/24 for the p.m. dose, 8/10/24 for the a.m. dose, 8/11/24 for the a.m. dose, 8/13/24 for the a.m. dose, 8/14/24 for the a.m. dose, 8/15/24 for the a.m. dose, 8/16/24 for the a.m. and p.m. doses, 8/22/24 for the a.m. dose, and 8/23/24 for the a.m. and p.m. doses. The documented blood glucose range was 149 to 198 for the doses given against the order to hold for a blood glucose less than 200. A MAR, dated 9/1/24 through 9/30/24, indicated insulin glargine-yfgn 34 units was given on 9/1/24 for the a.m. dose with a blood glucose of 134, on 9/2/24 for the a.m. dose with a blood glucose of 199, on 9/3/24 for the a.m. dose with a blood glucose of 187, and on 9/6/24 for the a.m. dose with a blood glucose of 195. During an interview, on 9/6/24 at 2:06 p.m., Licensed Practical Nurse (LPN) 7 indicated a medication was given if there was a check mark and initials on the MAR. There would be a code with initials when the medication was not given. LPN 7 indicated the insulin doses had been given on 9/1/24, 9/2/24, 9/3/24, and 9/6/24 with blood glucose levels less than 200. During an interview, on 9/6/24 at 2:21 p.m., the DON indicated the insulin doses were given against the hold order on multiple occasions. A current facility policy, titled "Change in Condition/Physician Notification Guidelines," dated 11/23 and received from the DON on 9/10/24 at 12:00 p.m., indicated "...physician notification is based on assessment findings and is to be documented in the medical record...."			

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	A current facility policy, titled "Medication Administration Policy," dated 6/1/22 and received from the DON on 9/10/24 at 11:58 a.m., indicated "...Check for vital signs or other tests to be done during or prior to medication administration...." A current facility policy, titled "Subcutaneous Insulin," undated and received from the Clinical Support Nurse on 9/10/24 at 1:00 p.m., indicated "...Administer to resident...as ordered..." 3.1-37(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview and record review, the facility failed to ensure staff stored a nebulizer mask and a CPAP/BiPap mask in a sanitary manner, failed to sanitize a CPAP/BiPap mask after it was found on the floor, and failed to ensure a resident receiving oxygen supplement therapy had an order for the oxygen for 3 of 3 residents reviewed for respiratory care. (Resident 58, 27 and B) Findings include: 1. During an observation, on 9/3/24 at 10:20 a.m., Resident 58 was resting in bed. A nebulizer mask was found lying on top of the nebulizer machine. It was not stored in a bag. The clinical record for Resident 58 was reviewed on 9/3/24 at 12:26 p.m. The diagnoses included, but were not limited to, history of traumatic brain injury, acute respiratory failure with hypoxia, and other diseases of the bronchus.	F 0695	F695 D Respiratory /Tracheostomy Care and Suctioning The facility respectfully requests paper compliance for this citation Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by both Federal and State laws. (1) Immediate action taken for those residents identified to have been affected: • Orders for Oxygen were audited and implemented for residents receiving oxygen. Residents #58, #27 were assessed, Resident #B no longer resides within the facility.	10/03/2024

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	A physician's order, initiated on 10/21/23, indicated to administer albuterol sulfate (a respiratory medication) 2.5 milligrams in 3 milliliters via nebulizer every six (6) hours as needed for shortness of breath and/or wheezing. During an interview, on 9/3/24 at 10:38 a.m., CNA 5 indicated the mask should not be stored on top of the nebulizer machine. During an interview, on 9/3/24 at 11:25 a.m., the Director of Nursing indicated the nebulizer mask was not stored appropriately. 2. During an observation, on 9/3/24 at 10:35 a.m., Resident 27 was sitting up in bed. A mask for a CPAP/BiPap (machine used to assist with breathing while sleeping) was noted to be on the floor. During an observation, on 9/3/24 at 10:36 a.m., CNA 5 entered the room, picked up the CPAP/BiPap mask from the floor and placed it on top of the machine. CNA 5 indicated the mask was not stored in a sanitary manner. She was not observed to have cleaned the mask prior to exiting the room. The clinical record for Resident 27 was reviewed on 9/10/24 at 10:56 a.m. The diagnoses included, but were not limited to, unspecified asthma, chronic respiratory failure with hypoxia, and obstructive sleep apnea. The resident did not have an order for a CPAP/BiPap machine. The resident did not have a care plan addressing the use of a CPAP/BiPap machine.		• Orders reviewed, and care plans updated to reflect residents' status for oxygen use. • Oxygen equipment, nebulizer and CPAP/BiPap were replaced and stored in a sanitary manner. (2) How did the facility identify those other residents that had the potential to be affected: • The DON/ADON/designee will audit current residents to ensure that all residents that require oxygen have current physician orders in place and their care plans reflect the resident's status. • Physician orders will be followed. (3) Measure put into place/Systemic changes: • The DON/ADON/designee will educate licensed nurses on policy and procedures for following physician orders and ensuring that the care plan reflects resident status. • Review new orders and new admissions in the morning clinical meeting, to determine those residents' requiring oxygen have current orders in place, and care plan reflects resident s status for oxygen use. • Unit managers will randomly audit oxygen liters during routine facility rounding 3 times weekly to determine physician orders are followed related to oxygen usage. (4) How the corrective actions will be monitored: • The DON/ADON/ designee will audit new orders during morning	

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	During an interview, on 9/10/24 at 12:33 p.m., Resident 27 indicated he used the machine every night and nursing staff put the mask on him. During an interview, on 9/3/24 at 11:26 a.m., the Director of Nursing indicated the mask should have been sanitized and placed in a bag with a new date. During an interview, on 9/10/24 at 12:05 p.m., the Director of Nursing (DON) indicated Resident 27 needed to have an order for the CPAP. During an interview, on 9/10/24 at 12:32 p.m., RN 6 indicated when the resident admitted to the facility he had an order for the CPAP. The order was discontinued in October of 2023 when he went out to the hospital.3. During an observation, on 9/3/24 at 10:51 a.m., Resident B was wearing oxygen at 3 liters. The clinical record for Resident B was reviewed on 9/3/24 at 1:25 p.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure, type 2 diabetes, stage 3 chronic kidney disease, obstructive sleep apnea, and retention of urine. The resident was admitted on 8/29/24. While reviewing the resident's physician's orders, the resident did not have an order for the use of oxygen. During an interview, on 9/3/24 at 3:01 p.m., the DON indicated she was not aware the resident did not have an order for oxygen. During an interview, on 9/10/24 at 12:00 p.m., the DON indicated they did not have a policy for physician's orders.		clinical meetings to ensure that new residents requiring oxygen have current orders in place and care plan reflects status for oxygen use. • The responsible party for this plan of correction will be the DON with ED oversight. • Audit reviews 3 times weekly for 6 months or until 100% compliance has been achieved for 3 months at which time the QA committee may decide to adjust the plan of care. • Audit findings will be brought to the Quality Assurance Performance Improvement Committee monthly for ongoing compliance review. (5) Date of Correction: • 10-3-2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING 00 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	A current facility policy, titled "CPAP/BiPap CLEANING POLICY," dated as last revised and received from the Director of Nursing on 9/10/24 at 11:58 a.m., indicated, "...Nebulizer/BiPap/CPAP mask and oxygen tubing is to be stored in plastic bag when not in use...." 3.1-47(a)(6)			
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails Based on observation, interview and record review, the facility failed to ensure assessments were completed and a consent was obtained prior to the use of side rails for 2 of 3 residents reviewed for accident hazards. (Resident O and 63) Findings include: 1. During an observation, on 9/3/24 at 9:34 a.m., 9/3/24 at 10:49 a.m., 9/4/24 at 9:19 a.m., 9/5/24 at 2:42 p.m., 9/6/24 at 1:40 p.m., 9/9/24 at 2:54 p.m., and 9/10/24 at 10:47 a.m., a side rail was in the raised position and in use on Resident O's bed. The clinical record for Resident O was reviewed on 9/4/24 at 2:02 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, type 2 diabetes mellitus with diabetic neuropathy and hyperglycemia, unsteadiness on feet, weakness, lack of coordination, difficulty in walking, peripheral vascular disease, anxiety disorder, chronic pain syndrome, hypertension, and major depressive disorder. A side rail assessment, completed on 7/24/23, indicated Resident O did not need a side rail to	F 0700	F700 D Bed Rails The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: • Residents #O and #63 had bed rail assessments completed, orders reviewed, and care plans updated. 2)How the facility identified other residents: • Bed rail assessments were completed on current facility	10/03/2024

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	assist in bed mobility. The electronic record did not have documentation showing the risks and benefits were explained to Resident O or a consent was obtained prior to the use of side rails. A physical therapy treatment note, dated 6/25/24, indicated Resident O completed transfers using the "bedside rail" during his therapy session. 2. During an observation, on 9/3/24 at 9:37 a.m., 9/4/24 at 9:29 a.m., 9/5/24 at 1:23 p.m., and 9/9/24 at 2:54 p.m., a side rail was in place on Resident 63's bed. The clinical record for Resident 63 was reviewed on 9/4/24 at 2:03 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, lack of coordination, difficulty in walking, bipolar disorder, generalized anxiety disorder, seizures, gastroesophageal reflux, hypertension, pain in right knee, pain in left knee, and age-related physical debility. A side rail assessment was completed on 2/20/24 at 1:09 p.m. The assessment had the following question, "Risks & Benefits have been explained & agreed to bed rail utilization", and indicated one of the following should be selected: "1. Resident representative notified and agreed" or "2. Resident notified and agreed". Neither option was selected. The electronic record did not have documentation showing the risks and benefits were explained to Resident 63 or a consent was obtained prior to the use of side rails. A facility document, titled "Admission Packet,"		residents. • Assessments will include consent and education. • Any resident residing within the facility had the potential to be affected, however none identified to be adversely affected. 3)Measures put into place/ System changes: • Education on Bed Rail policy and procedure. • Education to nursing on correct completion of Bed rail assessment. • MDS Coordinator will monitor compliance on completion of Bed Rail assessment on admission. • Facility wide care plan audit completed for those residents identified to utilize bed rails. 4)How the corrective actions will be monitored: • The responsible party for this plan of correction will be the Director of Nursing/Designee with Executive Director oversight. • MDS will monitor compliance of completion of bed rail assessment will admission. Compliance will include orders and care plan completion • The results of audits will be reviewed in Quality Assurance Meeting for 6 months or until 100% compliance has been maintained for 3 months. The facility through the QAPI program, will review, update, and make changes as needed for sustaining substantial compliance.	

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	was found in the electronic record for Resident O and 63. The document indicated "...Prior to installing a side or bed rail, the Facility will attempt to use appropriate alternatives. If the Facility determines it is necessary to use a bed or side rail, the Facility will (1) assess the Resident for risk of entrapment from bed rails prior to installation; (2) review the risks and benefits of bed rails with the Resident, Resident Representative and/or Resident Representative and obtain informed consent prior to installation..." A current policy, titled "Policy and Procedure Subject: Bedrails," dated 11-22 and received from the Clinical Support nurse on 9/5/24 at 9:00 a.m., indicated "...when bed/side rails are requested...the admitting nurse will complete the Side Rail Evaluation...When bed/side rails are deemed to be appropriate for the resident, upon completion of the Side Rail Evaluation, the admitting nurse will review risks and benefits and obtain informed consent." 3.1-45(a)(1)		5)Date of compliance: 10-3-2024	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on interview and record review, the facility failed to ensure a PRN (as needed) psychotropic medication was not ordered beyond 14 days or the attending physician documented their rationale in the resident's medical record to indicate the duration for the PRN order for 2 of 5 residents reviewed for unnecessary medications. (Resident K and 183) Findings include: 1. The clinical record for Resident K was reviewed	F 0758	F 758 D Psyche/Prn Medications/Unnecessary Drug The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the	10/03/2024

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	on 9/5/24 at 10:54 a.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, fibromyalgia, type 2 diabetes mellitus with hyperglycemia, recurrent major depressive disorder with psychotic symptoms, insomnia, unspecified affective mood disorder, anxiety disorder, post-traumatic stress disorder, and unspecified psychosis not due to a substance or known physiological condition. A physician's order, dated 2/9/24, indicated to give 1 tablet of alprazolam (an anti-anxiety medication) 0.25 mg (milligrams) by mouth every 12 hours as needed for anxiety with a 90 day stop date of 5/9/24. A physician's order, dated 5/16/24, indicated to give 1 tablet of alprazolam 0.25 mg by mouth every 12 hours as needed for anxiety with a 90 day stop date of 8/14/24. A physician's order, dated 8/15/24, indicated to give 1 tablet of alprazolam 0.25 mg by mouth every 12 hours as needed for anxiety with no end date given. During an interview, on 9/9/24 at 9:22 a.m., the Director of Nursing (DON) indicated she had not noticed the current PRN alprazolam order did not have a stop date. She could not find any documentation of a clinical reasoning from the physician for the extended duration of the PRN orders.2. The clinical record for Resident 183 was reviewed on 9/4/23 at 2:36 p.m. The diagnoses included, but were not limited to, severe bipolar disorder with psychotic features, type 2 diabetes, and irritable bowel syndrome. A physician's order, with a start date of 8/23/24,		facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: • The physician notified regarding resident's #K, and #183, to review psychotropic medication and provide documented rational for the duration of psychotropic PRN order. 2) How the facility identified other residents: • Any resident that received a PRN psychotropic medication had the potential to be affected however none were affected. • An audit will be conducted to identify any resident that may have a PRN psychotropic order and documentation of the rational in the resident's medical record to indicate the duration for the PRN order. • Identified issues were reported to physician for review. 3) Measures put into place/ System changes: • Inservice completed with licensed nursing staff and social services on Medication Management of Psychotropic Agents. • Pharmacy will review medication regimes for those residents	

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	indicated to give clonazepam (an anti-anxiety medication) 0.5 mg every 12 hours as needed. The order for the clonazepam did not have an end/stop date. During an interview, on 9/9/24 at 2:03 p.m., the DON indicated she did not see a stop date for the PRN order. During an interview, on 9/9/24 at 2:34 p.m., the Clinical Support nurse indicated as needed psychotropics should have stop dates within 14 days. A current policy, titled "Psychotropic Drug Policy. Gradual Dose Reduction, PRN Psychotropics," not dated and received from the Clinical Support nurse on 9/10/24 at 9:35 a.m., indicated "...PRN Psychotropics hypnotics, antianxiety or antidepressant medications shall not be used beyond 14 days unless the prescribing practitioner indicates the clinical rationale for extended use and the expected duration for PRN use of the medication...." 3.1-48(a)(2)		receiving psychotropic medications monthly and report any irregularities to the Director of Nursing. • The Director of Nursing will ensure notification of physician. • PRN order for psychotropic agents is limited to 14 days. • Renewal of these agents will be required every 14 days along with a direct examination and a new order to receive additional supply of medication. • Care plans will be reviewed and revised as appropriate. 4) How the corrective actions will be monitored: • Responsible party for this plan of correction is the Director of Nursing/Designee and Social Services Director who will review/audit new admission orders, 24-hour reports, and new orders during scheduled clinical meetings 5 days weekly to determine prn psychotropic medications are only ordered for 14 days, then reevaluated, new order received and documentation of rational exists. • Identified concerns will be addressed immediately. • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the	

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			plan of correction as indicated. 5) Date of compliance: • 10-3-2024	
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview and record review, the facility failed to ensure food was being served at proper (safe and appetizing) temperature for 1 of 1 kitchen reviewed for safe food temperatures. Findings include: During an interview, on 9/3/24 at 11:22 a.m., Resident E indicated room trays were often delivered late, and the food was cold. The posted mealtimes were as followed: Breakfast: 7:00 a.m. to 8:00 a.m. Lunch: 12:00 p.m. to 1:00 p.m. Dinner: 5:00 p.m. to 6:00 p.m. During a continuous dining observation, on 9/3/24 from 12:17 p.m. to 12:57 p.m., 30 residents in the dining room were served lunch. During a continuous dining observation, on 9/3/24 from 12:57 p.m. to 1:08 p.m., room trays were delivered to residents on the 200 hall and 400 hall. During a continuous dining observation, on 9/3/24 from 1:08 p.m. to 1:20 p.m., room trays were delivered to residents on the 500 hall and 600 hall. During the delivery of the room trays on the 500 hall, at 1:17 p.m., a food temperature check was requested on the last room tray.	F 0804	F 804 Nutritive Value/Palatable/Prefer Temp The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: • No resident was identified to have had an adverse effect. 2) How the facility identified other residents: • Any resident that resides in the facility and receives a diet had the potential to have been affected, however no resident was identified. 3) Measures put into place/ System changes:	10/03/2024

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	During an observation and interview, on 9/3/24 at 1:17 p.m., the Dietary Manager checked the temperature of the meal and indicated the hot foods should be served at 120 degrees Fahrenheit and the cold foods should be served at 45 degrees Fahrenheit. The Dietary Manager indicated if the food did not meet the recommended temperatures, the food would be reheated. The temperatures of the last room tray were as followed: a. The cheeseburger was 106 degrees Fahrenheit. b. The potato salad was 51 degrees Fahrenheit. c. The watermelon was 65 degrees Fahrenheit. During an observation, on 9/3/24 at 1:20 p.m., the last room tray was delivered with the hot food below the recommended temperature (greater than 135 degrees Fahrenheit) and the cold food was above the recommended temperature (less than 41 degrees Fahrenheit). During an interview, on 9/4/24 at 10:39 a.m., Resident C indicated the food being served was bland, cold, and the meal trays brought to the resident's room were delivered late. During an interview, on 9/6/24 at 1:31 p.m., Resident F indicated if they ate in the main dining room, the food temperatures were not a concern. If they ate the meals in their rooms, the food was cold when it was delivered. Resident F indicated complaints about the food had been discussed in the monthly resident council meetings. During an interview, on 9/6/24 at 1:33 p.m., Resident G indicated meal portions were not consistent, the food was bland, and if they chose to eat in their room, the food was cold when it was		• Education to dietary staff on the components of F804 for Nutritive Value and Appearance, Palatable and Prefer Temperatures of food and drink • Warming covers were ordered for tray carts to maintain meal temperatures. • Covers ordered for steam table food to maintain appropriate temperatures • Temperature logs will be reviewed 3 times weekly per ED/designee. 4) How the corrective actions will be monitored: • The responsible party for this plan of correction is the Dietary manager with Executive Director oversight. • Audits will be conducted 3 times weekly per dietary manager/designee to determine menus are palatable, attractive and at a safe and appetizing temperature. (to include breakfast, lunch and dinner). • Interviews per facility managers will be conducted randomly with residents using Angel Rounds audit tool, (at least 3 times weekly) to determine satisfaction with meals and temperatures of food. • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. • Review with resident council	

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	delivered. During an interview, on 9/9/24 at 2:35 p.m., the Interim Executive Director (ED) indicated he was aware of the ongoing complaints about the food. The concern had been discussed at resident council meetings almost every month. A current facility policy, titled "Food and Nutrition Services," dated as revised 11/22 and received from the Clinical Support nurse indicated "...The facility will provide each resident with a nourishing, palatable, well-balanced diet..." A facility document, titled "...Quick Resource Tool: Safe Food Handling..." dated 9/1/2021 and received from the Director of Nursing (DON) on 9/10/24 at 10:40 a.m., indicated "...The Dining Services Director/Cook(s) will be responsible for food preparation techniques which minimize the amount of time that the food items are exposed to temperatures greater than 41 degrees Fahrenheit and/or less than 135 degrees Fahrenheit, or per state regulation...All foods will be held at appropriate temperatures, greater than 135 degrees Fahrenheit (or as state regulation requires) for hot holding, and less than 41 degrees Fahrenheit for cold food holding...Temperature for Time/Temperature Control for Safety (TCS) foods will be recorded at time of service and monitored periodically during meal service periods..." This citation relates to Complaint IN00441593. 3.1-21(a)(1) 3.1-21(a)(2)		monthly meal service and food temperatures. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance: • 10-3-2024	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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	Based on observation, interview and record review, the facility failed to ensure a resident was placed in contact isolation immediately after being tested and while waiting for the results for Clostridium Difficile (C-Diff) for 1 of 1 resident reviewed for antibiotic use. (Resident B) Finding includes: During an observation, on 9/3/24 at 10:51 p.m., Resident B was on enhanced barrier precautions. The clinical record for Resident B was reviewed on 9/5/24 at 1:25 p.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure, type 2 diabetes, stage 3 chronic kidney disease, obstructive sleep apnea, and retention of urine. A nursing progress note, dated 9/2/24, indicated the resident had an episode of bowel movement which was foul smelling and mucus in appearance. The physician was notified. A physician's order, dated 9/2/24 at 11:30 a.m., indicated to obtain a stool sample. A physician's order, dated 9/2/24, indicated the Medical Doctor (MD) started Resident B on Flagyl (an antibiotic) 500 mg (milligram) by mouth three times per day for diarrhea to rule out C-Diff (a highly contagious bacteria which causes diarrhea and inflammation of the colon). A physician's order, dated 9/3/24 at 6:00 p.m., indicated the resident was to be in contact isolation every shift until C-Diff was ruled out. The resident was not placed into contact isolation immediately while being tested for C-Diff.	F 0880	F880 D Infection Prevention and Control. The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: • Resident B no longer resides within the facility. 2)How the facility identified other residents: • Any resident residing within the facility that was tested for Clostridium Difficile had the potential to be affected, however none were identified. • No other residents exhibited signs or symptoms. 3) Measures put into place/ System changes: • In servicing was provided by the Director of Nursing/IP/Designee to ensure nursing staff are educated and competent on infection control practices related to contact isolation. • New nursing employees will be educated on infection control	10/03/2024

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	Resident B was not in contact isolation for over 24 hours after being tested. During enhanced barrier precautions, personal protective equipment (PPE) was not required to be put on every time when entering the room. Contact isolation required PPE every time when entering a room. During an interview, on 9/3/24 at 3:01 p.m., the Director of Nursing (DON) indicated when you get an order for a stool sample to rule out C-Diff, a resident should be put in contact isolation until they get the results back. A current policy, titled "Clostridium Difficile," dated as effective 6/14/24 and received from the DON indicated "...Resident with diarrhea and suspected CDI are placed on contact precautions while awaiting laboratory results...." 3.1-18(j)		practices upon hire, annually and prn. • Facility infection control audits will be conducted weekly by Director of Nursing/designee to ensure correct infection control practices are being utilized. 4) How the corrective actions will be monitored: • The responsible party for this plan of correction is the Director of Nursing /Infection Preventionist with Executive Director oversight. • The results of audits will be reviewed in scheduled morning/clinical meetings and Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance: 10-3-2024	