STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 00 B. WING	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Nursing Home Complaints IN00418710 and IN00421830. This visit included a State Residential Licensure Survey and Investigation of Residential Complaint IN00417446. This visit was in conjunction with the Investigation of Nursing Home Complaint IN00423065. Complaint IN00418710 - Federal deficiencies related to the allegations are cited at F585, F622, F689, and F9999. Complaint IN00421830 - No deficiencies related to the allegations are cited. Complaint IN00423065 - Federal deficiencies related to the allegations are cited at F684. Residential Complaint IN00417446 - State deficiencies related to the allegations are cited at R145. Survey dates: November 27, 28, 29, 30, December 1, 4, 5, & 6, 2023 Facility number: 000439 Provider number: 155716 AIM number: 100275070 Census Bed Type: SNF/NF: 109 SNF: 10 Residential: 10 Total: 129	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey and Complaint survey conducted December 6, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of January 1, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tara Trevino	Executive Director	12/28/2023

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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	Census Payor Type: Medicare: 7 Medicaid: 86 Other: 26 Total: 119 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 14, 2023.			
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 assessments were completed for residents that self administered medications for 2 of 2 random observations. A resident was observed self administering a breathing treatment, and a resident was observed self administering eye drops. (Resident 94, Resident 14) Findings include: 1. On 11/28/23 a 9:54 A.M., Resident 94 was observed sitting on the edge of her bed self administering a breathing treatment. Staff was not observed in the room. On 12/1/23 at 1:17 P.M., Resident 94's clinical record was reviewed. Diagnosis included, but was not limited to, respiratory failure. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 11/11/23, indicated no	F 0554	**F554** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident 94 has been discharged from the facility. Resident 14 has a Self-Administration Medication Safety Screen completed, physician order for self-administration received and a care plan in place. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any resident who participates in	01/01/2024

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	cognitive impairment. Current physician orders included, but were not limited to: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG (milligram)/3ML (milliliter) (Ipratropium-Albuterol) 1 vial inhale orally four times a day, dated 11/3/23. The EMR (electronic medical record) lacked an order for self administration of medications. The EMR lacked a care plan for self administration of medications. The EMR lacked a self administration assessment. On 12/4/23 at 9:03 A.M., the Administrator indicated she was unsure if Resident 94 had been assessed to self administer medications, and would need to check with the nurses. At that time, a self administration of medications assessment had been requested and not provided. On 12/5/23 at 8:58 A.M., a hand written self administration of medications assessment was provided, dated 11/13/23. The assessment was not in the resident's clinical record. 2. On 12/1/23 at 10:17 A.M., Resident 14 was observed in her room self administering eye drops into both eyes. At that time, Resident 14 indicated she kept the bottle of eye drops in her room, and administered them on her own. On 12/1/23 at 1:10 P.M., Resident 14's clinical record was reviewed. Diagnosis included, but was not limited to, bilateral glaucoma. The most recent quarterly MDS Assessment, dated 10/26/23, indicated no cognitive impairment.		self-administration of medications has the potential to be affected. Residents who are self-administering medications have a Self-Administration Medication Safety Screen completed, physician's order, and care plan in place. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The pharmacy policy for Self-Administration of Medications by Residents has been reviewed by the IDT and determined to remain appropriate. Nurses and QMAs were educated on the process that must be completed prior to Self-Administration of Medications. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit tool was created to monitor the presence of Self-Administration Medication Safety Screen, physician orders, and a care plan for residents who are Self-Administering Medications. Audit will be completed by the DON or designee on five residents twice weekly for four weeks; then	

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	Current physician orders included, but were not limited to: Latanoprost Ophthalmic Solution 0.005 % (Latanoprost) Instill 1 drop in both eyes one time a day, dated 3/4/23. The EMR lacked an order for self administration of medications. The EMR lacked a care plan for self administration of medications. The EMR lacked a self administration assessment. On 12/5/23 at 8:58 A.M., a hand written self administration of medications assessment was provided, dated 11/13/23. The assessment was not in the resident's clinical record. On 12/4/23 at 1:07 P.M., the Administrator provided a current non-dated Self-Administration of Medications by Residents policy that indicated "Each resident who desires to self-administer medication is permitted to do so if the facility's interdisciplinary team and/or facility policy allows or has determined that the practice would be safe for the resident and other residents of the facility ... The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment form, which is placed in the resident's medical record". 3.1-11(a)		weekly for four weeks; then every other week times four; then monthly times two. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	
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			

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	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); (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			

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	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 interview and record review, the facility failed to ensure notification to the physician and family representative was completed following a change of resident condition for 1 of 6 residents reviewed for nutrition. The physician nor family representative was notified following a resident's significant weight loss. (Resident F) Finding includes: On 11/29/23 at 1:21 P.M., Resident F's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease, hemiplegia/hemiparesis, anxiety and depression. The most recent admission MDS (Minimum Data Set) Assessment, dated 10/11/23, indicated a severe cognitive impairment and no swallowing or dental concerns. Weights included, but were not limited to, the following: 10/3/23 112.6 pounds 11/2/23 108.4 pounds 11/6/23 101.4 pounds Resident F experienced a 9.95% weight loss from 10/3/23 through 11/6/23. A current nutritional care plan included, but was not limited to, the following intervention: Monitor/record/report to MD (Medical Doctor) significant weight loss: 3 pounds in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months, dated 10/17/23.	F 0580	**F580** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The physician and family of Resident F were notified of significant weight loss. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any Resident with a significant weight loss has the potential to be affected. All residents with significant weight loss have had family and physician notification. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The policy titled Provider Notification Guidelines was reviewed by the IDT and determined to remain appropriate. Nurses were educated on the requirements for physician notification and documentation of	01/01/2024

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	Progress notes related to Resident F's significant weight loss included: 11/28/23 at 10:26 A.M. WEIGHT WARNING: Value: 101.4 Vital Date: 2023-11-06 15:18:00.0 -5.0% change [6.5% , 7.0] -7.5% change [9.9% , 11.2] RD (Registered Dietician) review of weights due to declining weight ... Requesting weekly weights, fortified foods, and 90mL (milliliters) MedPass (or equivalent) BID (twice a day). Following. A monthly summary, dated 11/7/23 and signed by Licensed Practical Nurse (LPN) 27, indicated a weight of 101.4 on 11/6/23. No additional information related to the weight loss was indicated. The clinical record lacked notification to the physician or family representative following Resident F's significant weight loss on 11/6/23. On 12/1/23 at 10:11 A.M., the Assistant Director of Nursing (ADON) indicated the nurse on the floor would be the one to recognize weight loss. Once the weight loss was identified, the nurse should have notified the Director of Nursing (DON), and the DON would notify the physician and family representative. Either the nurse or the DON would notify the dietician. On 12/4/23 at 1:08 P.M., a current Provider Notification Guidelines policy, dated 8/2022, was provided and indicated "To ensure the resident's physician or practitioner ... is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care".		the notification in the medical record. The IDT will identify which residents have had a weight change requiring notification during clinical meeting weekly and notify nurses to make the calls. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit was created to monitor physician and family notification of significant weight loss. DON or designee will complete audit on five residents twice weekly for four weeks; then weekly for four weeks; then every other week times four; then monthly times two. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	

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	3.1-5(a)(2)			
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her			

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	name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the			

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	resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on interview and record review, the facility failed to ensure grievances were documented and resolved for 1 of 1 residents reviewed for misappropriation of property. (Resident S) Finding includes: During an anonymous interview on 12/4/23 at 3:05 P.M., it was indicated that an oral grievance was filed on 9/17/23 with Social Service Director (SSD) 7 in regard to Resident S's missing iPad. SSD 7 opened an investigation into the missing iPad, but was unable to locate the device, and indicated the facility would reimburse Resident S for the iPad. Reimbursement was never received. On 12/4/23 at 12:55 P.M., Resident S's clinical record was reviewed. Diagnosis included, but was	F 0585	**F585** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident S and their family will be contacted to determine the presence of any unresolved grievances. The conversation will be documented, and any grievances identified will be addressed following the Resident Concern/ Grievance policy. **How other residents having the potential to be affected by the same deficient practice will be**	01/01/2024

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	not limited to, dementia. The most recent annual MDS (Minimum Data Set) Assessment, dated 6/23/23, indicated Resident S had mild cognitive impairment. An inventory list, dated 1/24/23, indicated Resident S had one iPad/iPod. The clinical record lacked documentation related to the missing item or related grievance. On 12/5/23 at 10:18 A.M., SSD 7 indicated she was informed of Resident S's missing iPad and started an investigation, but when she called the resident's family member to update them on the progress, the family member said to disregard the investigation into the iPad. At that time, SSD 7 was unable to produce any documentation related to the grievance or investigation. During the Resident Council Meeting on 12/1/23 at 2:06 P.M., 8 residents indicated that grievances were only filed verbally, and they were unsure how to submit a written grievance. On 12/5/23 at 11:57 A.M., the Administrator indicated that grievances were not being documented, but would be documented going forward. On 12/5/23 at 1:33 P.M., a current Resident Concern / Grievance policy, dated 8/2023, indicated "Employees should document concerns on the paper Resident Concern form ... The department leader will document the resolution on the concern form using an addendum when needed and will follow up with the person reporting the concern to explain the resolution".		**identified and what corrective action will be taken:** Any Resident with a Grievance has the potential to be affected. Any Resident expressing a grievance will have the Grievance documented on the form and the Grievance policy will be followed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The policy titled Resident Concern/Grievance was reviewed by the IDT and determined to be appropriate. Staff from all departments were educated on the process for completing a grievance form. Information regarding how to file a written grievance was posted in several prominent areas of the facility and forms were placed at each nurses' station and the reception desk. Resident Council President was informed of the process for filing a written grievance form. Information regarding how to make a verbal or written Grievance outside of Resident Council meetings will be provided during each resident council meeting going forward. Social Services was educated on the tracking and monitoring of Concern/ Grievance forms for completion. **How the corrective action will be monitored to ensure the deficient practice will not**	

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	This citation relates to complaint IN00418710. 3.1-7(a)(2) 3.1-7(b)		**recur, i.e., what quality assurance program will be put into place:** An audit tool was designed to ensure that Grievances are addressed and documented. The administrator or designee will audit the Grievance log weekly times six weeks; then every other week times five; then monthly times two. The administrator or designee will audit Resident Council minutes monthly to ensure that the procedure for filing a Grievance was presented. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's			

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	155716	A. BUILDING 00 B. WING	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

(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
	needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that			

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	the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on interview and record review, the facility failed to ensure a resident's discharge was	F 0622	**F622** **What corrective action will be**	01/01/2024

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	documented in the clinical record for 1 of 3 residents reviewed for discharge. (Resident S) Finding includes: On 12/4/23 at 12:55 P.M., Resident S's clinical record was reviewed. Resident S was discharged to the hospital on 9/13/23 and was anticipated to return. A Discharge return anticipated MDS (Minimum Data Set) Assessment was submitted on 9/13/23. A progress note, dated 9/14/23, indicated "unwitnessed fall discussed in IDT (Interdisciplinary Team). Fall with major injury. Sent to ER (emergency room) for eval (evaluation) and tx (treatment)". A progress note, dated 9/17/23, indicated "Discharge Return Anticipated w. (with) ARD (Assessment Reference Date) 9/13/23 Section K completed on this date". A current discharge care plan, revised 8/10/23, indicated "my d/c (discharge) plans are to stay here at [name of facility] for long term care". The clinical record lacked any documentation in regard to the outcome of Resident S after 9/17/23. The clinical record lacked physician orders for transfer to the ER or discharge from the facility. On 12/4/23 at 2:49 P.M., the Administrator indicated Resident S went to the hospital and then was transferred to an inpatient hospice where the resident passed away. She indicated the Director of Admissions followed up with residents who are sent to the hospital. At that time, she indicated		**accomplished for those residents found to have been affected by the deficient practice:** Resident S was previously discharged. Unable to change past documentation. Will apply corrective action for all future discharges. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any resident who discharges has the potential to be affected. Proper discharge documentation will be completed for future discharges. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Facility Discharge Policy was reviewed by IDT and determined to remain appropriate. Nurses and Social Services have been educated on the paperwork and orders required for discharge documentation. IDT will review discharges five times a week in clinical meetings for the completion of documentation and any necessary follow-up actions. **How the corrective action will be monitored to ensure the**	

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	that she wasn't sure when family came to retrieve the resident's belongings out of her room. On 12/5/23 at 8:39 A.M., the Director of Admissions indicated Resident S went to the hospital and then was transferred to an inpatient hospice where the resident passed away. She indicated the POA (power of attorney) notified her verbally that the resident would not be returning to the facility. She indicated Social Service Director (SSD) 7 followed up on residents who are sent to the hospital by logging into a hospital portal. On 12/5/23 at 8:48 A.M., SSD 7 indicated Resident S went to the hospital and then was transferred to an inpatient hospice where the resident passed away. She further indicated that all verbal notifications of discharge needed to be confirmed with the hospital which was done via a hospital portal. She did not have access to this portal. A hospital discharge summary, dated 9/15/23, requested on 12/5/23 at 10:54 A.M. by the facility, indicated the resident was discharged into the care of [name of hospice]. On 12/5/23 at 2:39 P.M., the Administrator indicated upon discharge a resident or resident's POA should receive a medication list, transfer forms, and discharge assessment describing the current Level of Care, and there should be an order from the physician in the clinical record for discharge. At that time, the Administrator indicated she was unable to locate those items in Resident S's clinical record. On 12/5/23 at 1:33 P.M., a current Discharge policy, dated 8/2022, indicated "a copy of the following will be provided to the resident and		**deficient practice will not recur, i.e., what quality assurance program will be put into place:** An Audit tool was developed to audit all discharges for the completion of required documentation. The Audit will be completed by DON or designee during the clinical meeting Five times per week for six months. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	

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	receiving facility and a copy will be filed in the resident's medical records: an evaluation of the resident's discharge needs; the post-discharge plan; and the discharge summary". This citation relates to complaint IN00418710. 3.1-12(a)(3) 3.1-12(a)(5)(A) 3.1-12(a)(6)(B)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure the MDS (Minimum Data Set) Assessment was completed accurately for 2 of 2 residents reviewed for MDS discrepancy. (Resident 76, Resident 16) Findings include: 1. On 11/29/23 at 2:32 P.M., Resident 76's clinical record was reviewed. Diagnoses included, but were not limited to, personal history of transient ischemic attack, vascular dementia, and cognitive communication deficit. The most recent quarterly MDS Assessment, dated 10/13/23, indicated Resident 76 was unable to be assessed for cognitive function due to rarely or never being understood and received an anticoagulant during the 7 day look back period (10/7/23 - 10/13/23). Current physician orders included, but were not limited to: Aspirin (an antiplatelet) Tablet - Give 81 mg	F 0641	**F641** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** MDS Coding for medications in section N was corrected for Residents 76 and 16. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected. MDSs were completed accurately. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**	01/01/2024

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	(milligrams) by mouth one time a day, dated 5/18/21. Physician orders lacked an order for an anticoagulant medication during the lookback period. 2. On 12/4/23 at 10:41 A.M., Resident 16's clinical record was reviewed. Diagnosis included, but was not limited to, Alzheimer's Disease. The most recent quarterly MDS Assessment, dated 9/2/23, indicated Resident 16 had severe cognitive impairment and received an antibiotic for 5 days of the 7 day lookback period (8/27/23 - 9/2/23). Physician orders lacked an order for an antibiotic medication during the lookback period. On 12/4/23 at 10:16 A.M., MDS Coordinator 9 indicated she was unable to identify an anticoagulant medication received by Resident 76 during the lookback period and assumed that the aspirin was coded as the anticoagulant. She further indicated she was unable to identify an antibiotic medication received by Resident 16 during the lookback period. On 12/5/23 at 11:46 A.M., the Administrator indicated that the facility follows the RAI (Resident Assessment Instrument) user's manual.		MDS nurses, DON, and ADON were educated on the coding of section N using the RAI manual. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit was created to monitor the accuracy of MDS coding in section N. The audit will be completed by DON or designee on Five MDSs twice weekly for 4 weeks; weekly times four weeks; every other week times four; and then monthly times two. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each			

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	resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			

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	Based on interview and record review, the facility failed to ensure baseline care plans were completed for newly admitted residents for 2 of 8 residents reviewed for accidents. (Resident P, Resident T) 1. On 12/1/23 at 1:31 P.M., Resident P's clinical record was reviewed. Admission date was 8/31/23. Diagnoses included, but were not limited to, Alzheimer's Disease, dementia, and anxiety. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 10/4/23, indicated a severe cognitive impairment, and one (1) fall with injury since the previous assessment on 9/8/23. A current risk for falls care plan was initiated 9/12/23. A Falls Risk Assessment was completed 8/31/23 that indicated "high fall risk". The EMR (electronic medical record) lacked a baseline care plan related to falls. On 12/4/23 at 1:55 P.M., a handwritten 48-hour care plan for baseline functional abilities was provided, with effective date 9/1/23. The form lacked information related to risk for falls. The form was not in the resident's clinical record. 2. On 11/30/23 at 10:19 A.M., Resident T's clinical record was reviewed. Resident T was admitted on 8/17/23. Diagnoses included, but were not limited to, dementia and muscle weakness. The most recent quarterly MDS Assessment, dated 11/2/23, indicated Resident T had severe cognitive impairment, required extensive assistance of 2 or more staff for bed mobility, transfers, and toileting, and had one fall with major injury since the prior assessment (8/22/23).	F 0655	**F655** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident P and Resident T have comprehensive care plans in place. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** New admissions have the potential to be affected. All new admissions will have a baseline care plan in place within 48 hours. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The policy titled Comprehensive Care Plan Guidelines was reviewed by the IDT and determined to remain appropriate. Nurses were educated on the policy and the need for a baseline care plan. Nurses were educated on how to create the baseline care plan in conjunction with the admission assessment. The IDT will review admissions during the clinical meeting five times per week for the completion of a baseline care plan.	01/01/2024

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	A current falls care plan was initiated 10/17/23. A Falls Risk Assessment was completed 8/20/23 that indicated "high fall risk". The clinical record lacked a baseline careplan related to falls. On 12/4/23 at 2:55 P.M., a handwritten 48-hour care plan for baseline functional abilities, dated 8/18/23, with the incorrect location (room number) was provided. The resident was not moved to the room listed on the report until 9/14/23. The form lacked information related to risk for falls. The form was not in the resident's clinical record. On 12/5/23 at 9:33 A.M., the Administrator indicated she wasn't sure why the room number was listed incorrectly. At that time, she indicated that there was some confusion for staff on how to create careplans in August when the EMR was switched. On 12/4/23 1:07 P.M., a current Comprehensive Care Plan policy, dated 8/2022, indicated "The 48-hour baseline care plan will be completed within 48 hours of admission and will be the temporary working care plan until the comprehensive care plan is completed per RAI [resident assessment indicator] guidelines".		**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit was created to monitor the completion of a baseline care plan. DON or designee will audit all new admissions during the clinical meeting five times a week for six months. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	
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			

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	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 assess a chronic wound and report changes to the physician for 1 of 3 residents reviewed for wound care. (Resident B) Finding includes: On 12/1/23 at 8:42 A.M., Resident B was observed to have a wound on her right shin. It had a thick crusty surface, was raised in the middle, and was red around the edges. At that time, the DON (Director of Nursing) measured the wound at 6cm (centimeters) x (by) 6cm. On 12/1/23 at 1:04 P.M., Resident B's clinical record was reviewed. Diagnosis included, but was not limited to, neoplasm of uncertain behavior of skin. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 11/10/23, indicated the resident was not cognitively impaired, required extensive assistance of 1 staff for transfers and toileting, and had no skin conditions. Physician orders included, but was not limited to: Please complete weekly skin assessment under assessment tab one time a day every Tue, dated 10/17/2023. A current ADL (activities of daily living) care plan, revised 9/14/22, indicated "I require extensive assist of 1 with hygiene and bathing. I need assistance because of limited mobility, cognitive deficits, and blindness".	F 0684	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The wound for resident B has been assessed. Resident B's family and physician have been notified of the status of the chronic wound. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Other residents with chronic wounds have the potential to be affected. All other residents with chronic wounds have been assessed and physicians have been notified of the status of the chronic wound. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The policy titled Pressure Injury and Skin Condition Assessment was reviewed by the IDT and determined to remain appropriate. Nurses were educated on the policy including completion of weekly wound assessments and physician notifications. The	01/01/2024

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	A current skin integrity care plan, revised 9/14/20, indicated "Open lesion on right lower leg- possible cancerous lesion as I have a hx (history) of multiple Ca (cancer) areas removed- open lesion is scaly/shiny in appearance - cont (continue) to be observed". An intervention, dated 3/3/20, indicated "Observe and 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)". Skin Only Evaluations were completed weekly from 11/30/22 - 12/2/23. Documentation of the open lesion on the resident's right lower leg occurred on the following days: 11/30/22 - "Resident has current skin issues." Length (cm): 3.0 Width (cm): 3.0 2/17/23 - "Resident has a chronic area on the right shin , light red with a crusty surface , she said shes [sic] had it for years." 2/18/23 - Right shin. Length (cm): 3.0 Width (cm): 4.0 11/23/23 - "Chronic skin area on the [sic] right lower leg, getting larger and thicker, has a diagnosis of neoplasm". Length (cm): 4.0 Width (cm): 5.0 There was no other documentation of the chronic skin area on any other skin assessment. Skin Assessments were completed on the following days: 9/23/23 - No discoloration or impairments in skin integrity 10/5/23 - No discoloration or impairments in skin integrity 11/21/23 - No discoloration or impairments in skin integrity		facility has designated a wound nurse who will oversee the wound program. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit tool was created to monitor the completion of wound assessment and physician notification. The audit will be completed by DON or designee on five residents with wounds every week for 6 weeks, then every other week times 5, then monthly times two. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** January 1, 2024	

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	12/2/23 - No discoloration or impairments in skin integrity A nurses note, dated 11/23/23, indicated "Resident has chronic neoplasm on her right lower leg that she has had for years, of recent is getting larger 4 cm x 5 cm , thick crusty surface , spoke with [name of POA (power of attorney)] want conseritive [sic] treatment like a topically [sic] cream , the NP (nurse practitioner) was inmformed [sic]". A wound assessment, dated 11/27/23, indicated the resident "has a history of a neoplasm at site with previous treatment" and the area on the right anterior calf was measured at 4.8cm x 3.3cm. A nurses note, dated 11/28/23, indicated "Notified NP regarding skin assessment and to advise on recommendation for referral to dermatology for suspected neoplasm of uncertain behavior on Residents right lower leg". In an anonymous interview on 12/4/23 at 8:19 A.M., it was indicated that Resident B had this wound prior to admission to the facility, and when she was admitted it was the size of a dime. It was indicated that family noticed that the wound had grown to the size of a fist during a visit with the resident the week of 11/13/23 and alerted staff to it. On 12/4/23 at 10:26 A.M., RN 15 indicated that chronic skin issues got documented in the weekly skin assessment even if the issue was not new in order to track changes. On 12/4/23 at 3:39 P.M., a current Pressure Injury and Skin Condition Assessment policy, dated 6/2022, indicated "pressure injuries and other			

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	ulcers ... will be assessed and measured at least every seven (7) days by a licensed nurse and documented in the resident's clinical record ... At the earliest sign of a pressure injury or other skin problem, the resident, legal representative, and attending physician will be notified". This citation relates to complaint IN00423065. 3.1-40(a)(2) 3.1-40(a)(3)			
F 0689 SS=G 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 adequate supervision and assistive devices to each resident to prevent accidents for 4 of 8 residents reviewed for falls. Care plans were not updated following each fall, and the clinical record lacked information related to falls resulting in a hip fracture. This deficient practice led to a fall with a fracture requiring hospitalization. (Resident P, Resident Y, Resident F, Resident T) Findings include: 1. On 12/1/23 at 1:31 P.M., Resident P's clinical record was reviewed. Admission date was 8/31/23. Diagnoses included, but were not limited	F 0689	**F689** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Fall Care Plan for Residents P, Y, F, and T were reviewed and updated to reflect all current interventions. IDT note created reflecting updated falls care plan for Residents P, Y, F, and T. **How other residents having the potential to be affected by the same deficient practice will be**	01/01/2024

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	to, Alzheimer's disease, dementia, and anxiety. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 10/4/23, indicated a severe cognitive impairment and 1 fall with injury since the previous assessment on 9/8/23. A current risk for falls care plan, initiated 9/12/23, included, but was not limited to, the following interventions: Motion sensor in place for safety, dated 11/20/23. Evaluate fall risk on admission and as needed, dated 9/12/23. A current fall with major injury - left intertrochanteric femur fracture care plan was dated 9/29/23. Resident P's clinical record lacked a baseline care plan for falls. Falls risk assessments were completed on the following dates: 8/31/23 9/3/23 9/11/23 9/29/23 10/3/23 11/16/23 All falls risk assessments indicated high fall risk. Progress notes indicated the following falls since admission: Fall 1 9/11/23 at 2:35 P.M. Fall was not witnessed. Resident found siting on the floor of another resident's room in between a chair and bedside table. Resident was wearing a non-skid sock. Neurological checks completed. A risk for falls care plan was initiated the following day, on		**identified and what corrective action will be taken:** Residents who have had a fall have the potential to be affected. All residents with falls in the past thirty days have had their care plan reviewed and updated and an IDT note made reflecting the updated falls care plan. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The policy titled Falls Program Guidelines was reviewed by the IDT and determined to remain appropriate. Nursing and IDT were educated on the Falls Program Guidelines policy. Falls including care plan updates, and IDT documentation will be reviewed/ completed in a clinical meeting five times a week. Fall Risk Assessments will be reviewed on all new admissions during the clinical review to identify any with High Fall Risk. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit tool was created to monitor the completion of care plan updates and IDT notes following every fall. Audit tool will be completed by DON or designee	

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	9/12/23. No Interdisciplinary Team (IDT) note was completed. Fall 2 9/13/23 at 4:15 P.M. Fall was not witnessed. Resident was found on the floor in the dining room on her back. Neurological checks were completed. The falls care plan was not updated with a new intervention following the fall. No IDT note was completed. Fall 3 9/14/23 at 7:15 P.M. A Certified Nurse Aide (CNA) indicated to a nurse that this resident and another had been arguing, Resident P struck the other resident on the left cheek causing that resident to push her walker into Resident P, knocking her down to the floor and causing a skin tear to the right elbow around 2-3cm (centimeters) long. Earlier in the day, the following progress note was entered at 5:00 P.M.: "[Resident] would not stay in the wheelchair this evening. she would propel herself around the unit then get up and start walking and refuse to sit back in the wheelchair. would try to redirect her back to a chair when she was found up walking for safety". Following the fall, the falls care plan was not updated with a new intervention. No IDT note was completed. Fall 4 9/18/23 at 6:45 P.M. "as this nurse was getting report from day shift nurse, CNA from day shift reported that she saw resident up out of wheelchair and fell against the dining room table and chair. Resident observed laying on her left side with her legs stretched outin [sic] front of her. Resident stated she hit her head on the chair and fell to the floor". Neurological checks were initiated, then stopped		five times per week for six months. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	

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	on 9/19/23 at 4:30 A.M. On 9/19/23, the falls care plan was updated with an intervention to anticipate needs. No IDT note was completed. Fall 5 9/20/23 at 2:45 A.M. Resident fell in between her and roommate's bed and landed on the floor. The nurse on duty observed the incident. The resident could not stand or walk alone and complained of both right and left leg pain. "No bruises or fracture seen upon inspection". The DON (Director of Nursing) was notified via text message, and the Nurse Practitioner (NP) was notified via binder. An IDT note dated 9/20/23 at 9:55 A.M. indicated a new fall intervention to offer more assistance with ADLs (activities of daily living) related to current COVID diagnosis and increased weakness. On 9/20/23 at 3:55 P.M. While staff was changing and turning the resident, the resident was holding her left leg grimacing in pain. A left hip x-ray was ordered and showed a left hip fracture. The resident was sent to the hospital for surgery and returned 9/26/23. A fall with major injury care plan was initiated 9/29/23. Fall 6 10/3/23 at 10:55 A.M. Fall was unwitnessed. Resident was observed sitting on the floor facing the bed. The resident's brief was "full of urine" and the room was slightly lit. Resident indicated at that time to the nurse "Thank God ... I don't know how long I'm gonna call for help". The resident indicated she did not hit her head and complained of lower back pain. An x-ray at that time showed no new fractures. Neurological checks were completed. The falls care plan was updated on 10/4/23 to include staff assist with toileting. No IDT note was completed.			

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	Fall 7 11/3/23 at 1:34 A.M. Fall was unwitnessed. Resident was attempting to self toilet and fell in room. An IDT note dated 11/3/23 at 9:51 A.M. indicated resident had a motion sensor that was sounding and would initiate every two hour toileting as a new intervention. Neurological checks completed and falls care plan updated with the new intervention. Fall 8 11/9/23 at 6:25 P.M. Fall was unwitnessed. A sensor alarm was sounding and resident was found lying on the floor with her head partially under the bed and legs bent. Resident complained of right elbow and right leg and hip pain. An x-ray at that time showed a fracture of the right hip. Neurological checks were not completed, and the falls care plan was not updated with a new intervention. No IDT note was completed. Fall 9 11/19/23 at 12:00 P.M. The resident was lowered to the floor when the nurse coming down the hall heard the alarm going off and found the resident coming out of bed. Neurological checks were not completed, and an IDT note was not documented. The falls care plan was updated with new interventions. On 12/4/23 at 10:42 A.M., Resident P was observed sitting in a wheelchair across from the nurse's station. An alarm was not observed. At that time, CNA 6 indicated Resident P did not have an alarm to the wheelchair or bed, and was unaware of any alarm that the resident currently had. 2. On 11/30/23 at 10:45 A.M., Resident Y's door			

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	was closed. On 12/4/23 at 10:43 A.M., Resident Y's door was observed closed. Resident Y was lying in bed with the call light hanging down from the head of the bed tangled in other cords, out of the resident's reach. On 11/29/23 at 1:48 P.M., Resident Y's clinical record was reviewed. Diagnoses included, but were not limited to, history of falling and muscle weakness. The most recent quarterly MDS Assessment, dated 9/28/23, indicated a severe cognitive impairment. Resident Y required extensive assistance of one staff with bed mobility, transfers, and toileting. A current risk for falls care plan initiated 8/19/22 included, but was not limited to, the following interventions: Call light within reach, dated 8/2/23. Encourage resident to have door open for safety, dated 11/16/23. A current risk for falls/injury care plan was dated 10/6/23. Falls risk assessments from 7/2023 through 12/2023 were completed on the following dates: 7/22/23 7/23/23 10/25/23 11/4/23 11/27/23 All falls risk assessments indicated a high fall risk. Progress notes indicated the following falls since 7/2023: Fall 1 7/22/23 at 4:30 P.M. Fall was unwitnessed.			

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	Resident indicated she was trying to pick up a piece of paper off the floor and fell. Resident was found lying on the right side in front of the recliner. A falls care plan was not observed to be in place at that time, nor was one initiated. Neurological checks were completed. No IDT note was completed. Fall 2 10/3/23 at 11:45 A.M. Fall was unwitnessed. Resident was found on the floor in front of the wheelchair. The resident indicated she slid out of it. Dycem was applied to the wheelchair cushion and the care plan updated. Neurological checks were completed. 10/4/23 at 12:20 P.M. Resident indicated she did not feel well. Speech was slurred and trunk control very weak. Eyes were pinpoint and not reactive. Resident was sent to the hospital and diagnosed with subacute lacunar infarction (a type of stroke) and dysmetria (poor coordination). Returned to the facility 10/6/23. Fall 3 11/4/23 at 12:15 A.M. Fall was unwitnessed. Resident was attempting to self toilet and fell in the bathroom. Neurological checks were initiated, but not completed from 11/4/23 at 8:45 A.M. till 4:45 P.M., then again from 11/5/23 at 8:45 A.M. till 4:45 P.M. The falls care plan was updated to toilet every 2 hours. Fall 4 11/15/23 at 10:45 A.M. Fall was unwitnessed. Resident was found on the floor in front of the wheelchair with legs out in front of her. Neurological checks were initiated, but not completed on 11/17/23 from 8:15 A.M. through 4:15 P.M. The falls care plan was updated to			

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	include encourage resident to have door open for safety. Fall 5 11/27/23 at 6:16 P.M. Fall was unwitnessed. Resident was found sitting on buttocks in the middle of her room on the floor. She was attempting to change pants. Neurological checks were not completed. The risk for falls care plan was updated for occupational therapy to expand therapy to include additional ADLs. A neurological assessment flow sheet was provided and indicated neurological checks were initiated on 11/3/23 at 9:00 P.M. Resident Y's clinical record did not indicate a reason for the checks. 3. On 11/30/23 at 10:50 A.M., Resident F was observed lying in bed. A call light was observed draped over the headboard, out of reach. At that time, Physical Therapy Assistant (PTA) 10 measured the bed height at 20 inches and indicated she thought the resident's bed should be locked at 20 inches. On 11/29/23 at 1:21 P.M., Resident F's clinical record was reviewed. Admission date was 10/3/23. Diagnoses included, but were not limited to, Alzheimer's disease, hemiplegia/hemiparesis, anxiety, and depression. The most recent admission MDS Assessment, dated 10/11/23, indicated a severe cognitive impairment, 1 fall since admission with injury, and a fracture related fall in the 6 months prior to admission. A current risk for falls care plan initiated 10/3/23 included, but were not limited to, the following interventions: Therapy to evaluate bed height. Locked at 19.5			

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	inches, dated 10/12/23. Call light within reach, dated 10/3/23. A falls risk assessment, dated 10/7/23, indicated a high risk for falls. Progress notes indicated the following falls since admission: Fall 1 10/10/23 at 1:35 P.M. Resident attempted to ambulate without assistance in the dining room. When resident stepped forward, her sweater caught in the locking handle of the wheelchair causing her to trip over the foot pedals. Dycem was placed in the wheelchair seat. At the time of the fall, the falls care plan had one intervention to make sure call light was within reach. Following the fall, a new intervention to only utilize foot pedals while transporting was added. No IDT note was completed. Fall 2 10/11/23 at 4:45 P.M. Fall was unwitnessed. Resident was found lying on the floor with legs stretched towards the bathroom door. Bleeding was observed coming from the back of her head. Neurological checks were initiated but not completed on 10/12/23 at 12:30 P.M., 10/12/23 at 2:30 P.M., and 10/13/23 at 2:30 P.M. An IDT note dated 10/12/23 indicated for therapy to evaluate for appropriate bed height. The falls care plan was updated. On 11/30/23 at 1:58 P.M., a neurological assessment flow sheet was provided that indicated neurological checks had been initiated for Resident F on 10/19/23 at 12:30 P.M. and ended 10/21/23 at 2:15 P.M. The form lacked 9 checks on 10/19/23 from 12:45 P.M through 6:15 P.M. At that time, a 15-minute monitoring form			

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	was provided as well that indicated Resident F had begun 15-minute checks on 10/20/23 at 11:00 P.M. and ended 10/22/23 at 10:45 P.M. The reason for the precaution was not indicated, but the word "corridor" was circled. Resident F's clinical record lacked a reason or any other indication for the neurological checks or 15-minute checks. The most recent update to the falls care plan was dated 10/12/23. On 12/4/23 at 11:04 A.M., the Administrator indicated after a fall, the clinical team would review the resident's care plan interventions and update as needed. On 12/5/23 at 12:00 P.M., LPN 4 indicated Resident F was not capable of using a call light due to a diagnosis of dementia, and was an inappropriate intervention for a falls care plan. 4. On 11/30/23 at 10:19 A.M., Resident T's clinical record was reviewed. Resident T was admitted on 8/17/23. Diagnoses included, but were not limited to, dementia and muscle weakness. The most recent quarterly MDS Assessment, dated 11/2/23, indicated Resident T had severe cognitive impairment, required extensive assistance of 2 or more staff for bed mobility, transfers, and toileting, and has had one fall with major injury since the prior assessment (8/22/23). A fall risk assessment, dated 8/20/23, indicated Resident T was a high risk for falls with a score of 14.0. The instructions on the Fall Risk Assessment form indicated "If the total score is 10 or greater the resident should be considered AT HIGH RISK for potential falls. A prevention protocol should be initiated IMMEDIATELY and documented on the care plan."			

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Progress notes indicated that Resident T sustained an unwitnessed fall on 10/16/23 at 5:53 P.M. while walking without her walker in another resident's room. This fall resulted in a left wrist fracture.

An orthopedic note, dated 10/17/23, indicated "L (left) wrist films show a 3 part intra-articular distal radial Fx (fracture), minimal shortening, loss of volar tilt. The fracture is in an acceptable position; therefore, surgical intervention is not required. Cast application x (times) 4 weeks with repeat x-rays in 4 weeks. The patient may use the extremity for most activities as comfort allows in the cast."

A falls care plan, initiated 10/17/23, indicated Resident T was "at risk for falls/injury due to: Gait/balance problems, Hx (history) falls - Fall with major injury fx of left distal radial metaphysis and subtle fx of ulnar styloid".

The clinical record lacked a falls care plan prior to 10/17/23.

On 12/1/23 at 10:15 A.M., the Assistant Director of Nursing (ADON) indicated she would expect there to be a care plan for fall if a resident were to be identified as a high falls risk on a falls risk assessment.

On 12/4/23 at 8:44 A.M., a current Fall Program Guidelines policy, dated 12/2022, indicated "the resident will be assessed for fall risk upon admission and quarterly. Interventions will be implemented if resident is determined to be at risk. Should a fall occur...the Interdisciplinary Team (IDT) should determine root cause and evaluate to ensure appropriate interventions are implemented

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	155716	A. BUILDING 00 B. WING	12/06/2023

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ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

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	... The resident care plan should be revised to reflect any new or change in interventions". This citation relates to complaint IN00418710. 3.1-45(a)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview the facility failed to ensure residents received necessary respiratory care and services in accordance with professional standards of practice for 3 of 3 residents reviewed for respiratory care. The facility failed to date tubing and label humidification bottles, and lacked a care plan for oxygen for a resident on oxygen. (Resident 30, Resident 271, Resident 83) Findings include: 1. On 11/28/23 at 10:28 A.M., Resident 30 was observed in his room sitting in a wheelchair wearing oxygen (O2) at 2 L (liters) via nasal cannula. There were no visible dates on the tubing, concentrator, and humidification bottle. On 11/29/23 at 1:14 P.M., Resident 30 was observed sitting in a wheelchair wearing portable	F 0695	**F695** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Oxygen tubing and humidifier bottles were labeled and dated for Residents 30, 271, and 83. Care plans for oxygen use are in place for Residents 30, 271, and 83. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Residents who use oxygen have the potential to be affected. The tubing and humidifier bottles are	01/01/2024

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	O2 at 2 L. The tubing lacked a dated label. On 11/29/23 at 12:54 P.M., Resident 30's clinical record was reviewed. Diagnoses included, but were not limited to, Pulmonary Fibrosis and dyspnea unspecified. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 11/4/23, indicated the resident was cognitively intact, needed supervision with transferring and toileting, and was on O2. Current physician orders included, but were not limited to,"change out and date all O2 humidified water, tubing, cannula, storage bag and wipe down equipment every Wednesday for equipment care," dated 9/3/23. Current care plans included, but were not limited to, "Potential for complications related to respiratory status", that included the intervention, but was not limited to, "oxygen as ordered," dated 3/23/22. 2. On 11/28/23 at 10:54 A.M., Resident 271 was observed lying in bed wearing O2, the tubing lacked a label. On 11/29/23 at 1:17 P.M., Resident 271 was observed lying in bed wearing O2. The tubing and concentrator both lacked a dated label. On 11/29/23 at 1:36 P.M., Resident 271's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease and shortness of breath. The most recent admission MDS Assessment, dated 11/19/23, indicated Resident 271 was		labeled and dated, and all have oxygen use care plans in place. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The policy titled Respiratory was reviewed by the IDT and determined to be appropriate. All residents with oxygen were reviewed to ensure orders were in place to change oxygen tubing as per policy. Nurses and QMAs were educated on the Respiratory policy. IDT will review new admissions with oxygen in clinical meetings to determine that the appropriate orders and care plans are in place. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit tool was created to monitor the presence of care plans and the dating of tubing and humidifiers. DON or designee will complete audit on five residents twice weekly for four weeks; then weekly for four weeks; then every other week times four; then monthly times two. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or	

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	cognitively intact, needed partial to moderate assistance with all ADLs (activities of daily living), and received oxygen. Current physician orders included, but were not limited to, "O2 sats (saturations) every shift. May apply O2 at/up to 2lpm (liters per minute) PRN (as needed) via nasal cannula to maintain sats > 90%, Resident may remove at times every shift related to Chronic Obstructive Pulmonary Disease," dated 11/21/23. The current care plan lacked documentation for oxygen use. On 12/4/23 at 2:55 P.M., the Administrator indicated that if the MDS indicated oxygen use, it had to be addressed on the comprehensive admission care plan. 3. On 11/28/23 at 12:55 P.M., Resident 83's oxygen tubing and humidification bottle was observed unlabeled and undated. On 11/29/23 at 1:05 P.M., Resident 83's humidification bottle was dated 11/20/23 and the tubing was not dated. On 11/30/23 at 10:25 A.M., Resident 83's humidification bottle was dated 11/20/23 and the tubing was not labeled or dated. On 12/1/23 at 9:37 A.M., Resident 83's humidification bottle was dated 11/20/23 and the tubing was not labeled or dated. On 12/1/23 at 9:18 A.M., Resident 83's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), obstructive sleep apnea, and dementia.		updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	

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	The most recent annual MDS Assessment, dated 11/7/23, indicated Resident 83 had severe cognitive impairment and received oxygen therapy. Current physician orders included, but were not limited to: Change all respiratory equipment (oxygen tubing, cannula, nebulizer mask and tubing, storage baggies) weekly. Label with resident name and room # (number), date, time, and staff initials one time a day every Wed (Wednesday) for infection control, dated 12/14/22. O2 at 2L/min (liters per minute) via Nasal Cannula continuous or to keep O2 sat > 88%, dated 12/13/22. The TAR (treatment administration record) indicated the respiratory equipment had been changed and labeled on 11/22/23 and 11/29/23. During an interview on 11/29/23 at 1:20 P.M., RN (Registered Nurse) 26 indicated the tubing should be dated and initialed, and there should be an order to change the oxygen tubing. The nurse should change the tubing Sunday night during night shift. On 12/25/23 at 10:06 A.M., a current Respiratory policy, dated 9/22, indicated "change oxygen cannula and tubing monthly and as necessary". 3.1-47(a)(6)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility			

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	must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to maintain safe and secure storage of medications for 4 of 4 medication carts observed and 2 of 2 medication storage rooms observed. Loose pills were observed in medication carts, and refrigerator temperature logs were not filled out completely in medication rooms. (Southeast, Northeast, West, and Pavilion) Findings include: 1. On 12/5/23 at 8:52 A.M., the following was observed on the Northeast/Southeast Unit: The medication cart was observed with the	F 0761	**F761** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Medication carts had loose pills removed and destroyed. Refrigerator temps were checked and logged. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	01/01/2024

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	following loose pills in the drawers: 1 small white round tablet with marking 20/15 1 small white round tablet with marking 12 on one side and T on the other 1 gray oval tablet with marking m10 1 white oval tablet with marking U on one side and 227 on the other At that time, Registered Nurse (RN) 12 indicated that any staff could clean out the medication carts, as it was not assigned to any certain person or shift. The refrigerator temperature logs from November/December in the medication storage room were observed with the following dates not filled out: Southeast medication refrigerator: 11/1/23 through 11/6/23 11/8/23 through 11/19/23 11/21/23 11/24/23 through 11/26/23 12/2/23 through 12/3/23 Northeast medication refrigerator: 11/1/23 through 11/6/23 11/8/23 through 11/21/23 11/24/23 through 11/25/23 12/2/23 through 12/3/23 2. On 12/5/23 at 9:00 A.M., the following was observed on the Pavilion Unit: The medication cart was observed with the following loose pills in the drawers: 1 small white round tablets with marking 5 on one side and U on the other 2 small white half tablets with no visible markings 1 white oval tablet with marking E on one side and 03 on the other 1 white oval tablet with marking U on one side and 111 on the other		**action will be taken:** Any residents receiving medications have the potential to be affected. Medication carts had loose pills removed and destroyed. Refrigerator temps were checked and logged. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The pharmacy policy titled Medication Storage in the Facility was reviewed and determined to be appropriate. Nurses and QMAs were educated on the policy and responsibility to clean carts and monitor refrigerator temperatures. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit tool was created to monitor for the presence of loose pills in the carts and the completion of temperature logs. DON or designee will monitor all medication rooms and carts twice weekly times four weeks; weekly times four weeks; every other week times four; and then monthly for two months. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or	

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	1 white oval tablet with marking E102 1 small white round tablet with marking ET59 1 small round pink tablet with marking A57 The refrigerator temperature logs from November/December in the medication storage room were observed with the following dates not filled out: 11/9/23 11/11/23 11/15/23 through 11/16/23 11/20/23 11/24/23 through 11/25/23 11/30/23 At that time, Licensed Practical Nurse (LPN) 16 indicated the night shift staff was responsible for filling out the temperature logs in the medication rooms, but was unsure who was responsible for cleaning out the medication carts. 3. On 12/5/23 at 9:18 A.M., the following was observed on the West Unit: Medication cart "A" was observed with the following loose pills in the drawers: Light yellow oval tablet with marking H128 Blue and white striped capsule with marking C5 100mg Medication cart "B" was observed with the following loose pills in the drawers: White oval tablet with marking 152 Yellow oval tablet with marking LU on one side and 300 on the other Yellow round tablet with 2 1/2 on one side and 893 on the other Pink round tablet with marking 262 At that time, LPN 4 indicated night shift was responsible for cleaning out the medication carts. On 12/5/23 at 11:58 A.M., the Administrator		updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	

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	provided a current non-dated Medication Storage in the Facility policy that indicated "Medications requiring refrigeration or temperatures between 36 degrees F (2 C) and 46 degrees F (8 C) are kept on a refrigerator with a thermometer to allow daily temperature monitoring". 3.1-25(m)			
F 0804 SS=E 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, record review, and interview, the facility failed to ensure food was served at palatable temperature for 1 of 1 trays tested for food temperature. Finding includes: On 12/1/23 at 8:00 A.M., a test tray was obtained from the Northeast/Southeast Hall. Food temperatures for that meal were as the following: Sausage -114 F Scrambled eggs - 133.7 F Milk - 39 F Orange Juice - 40 F The sausage tasted greasy, and the scramble eggs were bland.	F 0804	**F804** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Unable to correct the past temperature of a test tray. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Residents receiving meals from the kitchen have the potential to be affected. Residents will be	01/01/2024

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	On 12/1/23 at 3:06 P.M., during the Resident Council meeting, anonymous residents indicated: " The steam table broke last week, and the food has been cold." "Thanksgiving dinner was cold." " The food is not seasoned well. It is bland." " I ask for the salad because I do not like the food." On 12/5/23 at 11:19, an anonymous resident indicated "the temperature of the food varied each day. Breakfast was usually hot, but lunch and dinner vary greatly in temperature on various days." On 12/5/23 at 11:32 A.M., an anonymous resident indicated "food temperature varied day to day." On 12/1/23 at 6:40 A.M., Cook 22 indicated the temperature of food on the steam should be at least 145 F. On 12/1/23 at 8:57 A.M., Cook 22 presented a current non-dated Food Temperatures policy. The policy indicated "the temperature of all food items will get taken and properly recorded prior to the service of each meal ... temperatures should be taken periodically to assure hot food stay above 135 F and cold foods stay below 41 F during the holding and plating process and until the food leaves the service area". 3.1-21(a)(2)		served food at a palatable temperature. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** An Envive policy titled Kitchen Operations: Food Temperatures was reviewed and determined to be appropriate. Dietary staff were educated on the new policy. Logs remain in place for documentation of food temperatures. Insulated food carts were added to the food carts already in use. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit was created to monitor food temperatures delivered outside the kitchen. Dietary manager or designee will audit one tray (the last off the cart) for food temperatures. One tray will be tested three times a week for four weeks; then weekly times four weeks; then every other week until at least six months has been monitored. Test trays will be taken on various units and from different meals so that there is a representative sample. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or	

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			updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to store and prepare	F 0812	**F812** **What corrective action will be**	01/01/2024

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	food under sanitary conditions related to kitchen equipment and undated and expired dry goods for 2 of 2 observations. Findings include: The kitchen tour occurred between 8:51 A.M. and 11:40 A.M. on 11/27/23. During that time, the following was observed: In the dry storage area: 1 large can of spaghetti sauce dented 1 unlabeled can White powder on cans of apricot preserve Flour not dated when opened Bins not labeled Open box of Cheez-its not dated Open box of Fudge Rounds and Nutty Buddies not dated when opened 3 bags of fried crisp onions with best by date of Oct 29 23 3 bag of blue diamond almond sliced with best by June 13 23 3 bags of almonds with best by date of April 13 23 Bag of elbow macaroni open not dated Bag of open egg noodles not dated Box of powdered sugar not dated Brown sugar opened and not dated Box of marshmallows with used by date of May 19 23 Bag of shredded coconut wrapped unable to read open date Hot chocolate not dated when open In the walk in produce refrigerator: 1 box of cherry tomatoes not dated 1 box of onions not dated 1 box of grapes not dated 1 box of celery not dated 1 box of onions not dated		**accomplished for those residents found to have been affected by the deficient practice:** Any expired items were removed from the food storage areas. All items were dated with date received and/or date opened. Dishes were washed in machines that are operating at the appropriate temperature. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Amy resident who receives food from the kitchen has the potential to be affected. Any expired items were removed from the food storage areas. All items were dated with date received and/or date opened. Dishes were washed in machines that are operating at the appropriate temperature. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Envive policy titled Kitchen Operations: Food Storage was reviewed by the IDT and determined to be appropriate. Dietary Staff were educated on the new policy. The Envive policy titled Infection Control: Recording Dish Machine	

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	In the walk in dairy refrigerator: 1 container of cottage cheese open not dated 1 container of yogurt open not dated On the spice rack located on a back wall the following spices lacked an open date: 1 container of garlic 1 container of ground mustard 1 container of savory burger seasoning 1 container of savory steak rub 1 container of pumpkin spice 1 container of ground nutmeg 1 container of pumpkin spice 1 container of rotisserie chicken seasoning 1 container of garlic powder 1 container of cilantro 1 container of ground basil 1 container of blackened seasoning 1 container of Spanish paprika 1 container of parsley flakes 1 container of baking soda not dated when opened and expiration dated April 6 2020 1 bottle of red food coloring not dated On 11/27/23 at 10:41 A.M., the hot water temperature dish washer was 113.3 degrees F (Fahrenheit) and the second wash was 142 F. At that time, the Dietary Manager indicated the wash temperature was supposed to be 160 and the thermometer was broken. He was going to place a work order again today. He had been using a meat thermometer for temperature monitoring. He indicated that used the other 2 dishwashers in the facility to wash the dishes. On 11/27/23 at 11:31 A.M., the Dietary Manager indicated he had never been told to date boxes when opened. On 12/1/23 at 8:32 A.M., the following was		Temperatures/ Sanitizer was reviewed and determined to be appropriate. Dietary Staff were educated on the new policy and the need to use an alternate dish machine or method of cleaning dishes if the main dish machine is not working properly. Dietary staff will complete temperature logs for the dish machine. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit tool was created to monitor food storage and dating. The audit will be completed by the Administrator or Designee weekly for six months. An audit tool was created to monitor the dish machine temperatures. Dietary manager or designee will complete audit three times per week for six weeks; then weekly for six weeks; then every other week times six. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1,**	

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	observed in the dry storage area: Box of marshmallows undated and expired Box of brown sugar not dated Box of crushed crackers not dated On 12/1/23 at 8:45 A.M., Cook 22 indicated once a box was opened it should be dated. On 12/1/23 at 8:57 A.M., Cook 22 presented a current non-dated Food Storage policy that indicated "sufficient storage facilities will be provided to keep foods safe...clean, and dry...all containers must be legible and accurately labeled and dated ... foods should be covered, labeled, and dated...". 3.1-21(i)(2) 3.1-21(i)(3)		**2024**	
F 0838 SS=F Bldg. 00	483.70(e)(1)-(3) Facility Assessment §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity;			

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	(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.			

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	§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. Based on observation, record review, and interview, the facility failed to provide an accurate updated Facility Assessment. The Facility Assessment lacked specific services for residents with Intellectual Disabilities, feeding tubes, tracheotomies and dialysis, and staffing numbers for all departments. Finding includes: On 11/28/23 at 8:14 A.M., the current [name of facility] Facility Assessment, dated 9/12/23, was reviewed. The document indicated staffing numbers "varied", and it lacked specific resident population services for residents with Intellectual Disabilities, feeding tubes, dialysis, tracheotomies, and feeding tubes. On 12/5/23 at 9:33 A.M., the Administrator indicated there were no staffing numbers listed in the Facility Assessment, and that the services offered for residents were generalized. She further indicated services such as transportation for dialysis were implied. On 12/5/23 at 11:57 A.M., the Administrator provided a current Facility Assessment policy, dated 6/22. The policy indicated "the purpose of the assessment is used to make decisions about direct care staff needs, as well as the capabilities to provide services to the residents of the facility ... the intent of the facility assessment is to evaluate the resident population and identify the resources needed to provide the necessary person-centered care and services the residents requires ... the Resident Demographic/Facility Plan includes...conditions, acuity of populations	F 0838	**F838** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The Facility Assessment was updated to reflect specific services for residents with Intellectual Disabilities, Feeding Tubes, Tracheotomies and Dialysis as well as staffing numbers for all departments. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any resident of the facility has the potential to be affected. The Facility Assessment was updated to reflect specific services for residents with Intellectual Disabilities, Feeding Tubes, Tracheotomies and Dialysis as well as staffing numbers for all departments. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Envive policy titled Facility Assessment Policy was reviewed by the IDT and determined to	01/01/2024

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	and other information...that may affect the plan for the services the facility must provide".		remain appropriate. IDT Educated on the policy and reviewed the facility assessment for accuracy. Facility assessment will be reviewed monthly in QAPI and updated to reflect any changes. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** IDT will review the Facility assessment monthly in QAPI to determine if it is an accurate assessment of the current facility status. This will be ongoing based on the Envive policy. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	
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			

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	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); (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.			

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	§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 interview and record review, the facility failed to submit direct care staffing information to CMS (Centers for Medicare and Medicaid Services) for 1 of 1 quarters reviewed. (April, May, June, 2023) Finding includes: Failed to Submit Data for the Quarter and 1 Star Staffing Rating was triggered on the CMS PBJ (Payroll Based Journal) Data Report for Quarter 3 (April 1 - June 30, 2023). On 11/30/23 at 1:58 P.M., the Administrator indicated that she was aware that staffing information had not been submitted for the third quarter because the facility changed ownership in July and the information did not get submitted. She further indicated that was the reason for the 1 star staffing rating. On 12/4/23 at 1:06 P.M., the Administrator indicated there was no policy for direct care staffing information submission and the facility followed the federal guidelines.	F 0851	**F851** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The April, May June PBJ cannot be submitted as it is already past the deadline and data was retained by prior ownership. Envive has already submitted the July, August, and September PBJ data. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any resident has the potential to be affected. Corrective action has already been taken with the submission of quarter four data by Envive. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Envive has a corporate team who confirms that all PBJ data is entered by the facility and submits the data at that time.	01/01/2024

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			How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: IDT will confirm that the most recent quarter PBJ data was submitted during each QAPI meeting. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and			

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	following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and			

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	transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure the proper use of protective equipment to prevent the development and transmission of communicable diseases and infections in 1 of 2 residents reviewed for transmission based precautions and 1 of 3 residents reviewed for wound care. (Resident 99, Resident 10) Findings include: 1. On 12/04/23 at 3:37 P.M ., Social Services Director (SSD) 7 was observed coming out Resident 10's room with all of her PPE (Personal Protective Equipment) on and removed it in the hallway. The trash cans and hazardous waste containers were also observed in the hallway outside of the residents room. On 12/4/23 at 3:39 P.M., SSD 7 indicted that she was trained to remove the PPE outside the room. On 12/4/23 at 3:42 P.M., CNA (Certified Nursing Aide) 31 was observed coming out of Resident 10's room after removing her PPE inside the room with her used PPE in a plastic trash bag, and disposed of the bag in the containers outside of the room. On 12/4/23 at 3:45 P.M., CNA 31 indicated PPE equipment should be removed in the room and disposed of in containers within the room. She indicated this was the way she was taught by	F 0880	**F880** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident 10 is no longer in isolation. Resident 99; had dressing change completed with the proper use of PPE and handwashing. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Residents in or near an isolation room have the potential to be affected. Isolation rooms have been set up with hazardous waste and trash containers in the resident room to allow for proper use of PPE. Residents with wound care have the potential to be affected. All dressings were changed with the proper use of PPE and handwashing. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**	01/01/2024

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	[facility name]. On 12/4/23 at 3:58 P.M., the ADON (Assistant Director of Nursing) indicated it was the policy of [facility name] to remove the PPE on the inside of the resident's room. On 12/4/23 at 4:02 P.M., the Administer indicated the PPE should be taken off in the inside of the room, and the trash cans should be inside the room. On 12/4/23 at 4:16 P.M., the Administrator provided a current Personal Protective Equipment policy, dated 8/22, that indicated "a supply of protective clothing and equipment is ... maintained outside and inside the resident's room as needed ... employees who fail to use personal protective equipment when indicated may be disciplined in accordance will personnel policies...". 2. On 11/30/23 at 1:30 P.M., Licensed Practical Nurse (LPN) 4 and LPN 18 were observed performing a dressing change for Resident 99. Prior to assisting the resident, LPN 18 washed hands for 12 seconds and put gloves on. After removing the dressing, LPN 18 removed the gloves, and washed hands for 7 seconds with no soap lather, only put soap in hands and put them directly under the water. Gloves were put on again. LPN 18 applied packing to the wound with the right hand, then with the same hand obtained a bag that was sitting on the nightstand and handed it to LPN 4. LPN 18 then placed the right fingers inside the wound where the packing was. A dressing was placed on the wound, and LPN 18 then removed the gloves and washed hands with a 4 second lather. On 12/4/23 at 3:44 P.M., the Assistant Director of Nursing (ADON) indicated during handwashing,		The policy titled Handwashing/ Hand Hygiene was reviewed by the IDT and an update requested to change time for handwashing to a minimum of 20 seconds. Policy updated and determined to be appropriate. The policy titled Personal Protective Equipment was reviewed by the IDT and determine to remain appropriate. Staff in all departments were educated on the proper use of PPE and on handwashing. Housekeeping was educated on setting up an isolation room to include placing hazardous waste and trash containers in the room. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit was designed to monitor for the proper set up and use of PPE in isolation rooms. DON or designee will audit 3 isolation rooms two times per week for 6 weeks; then three rooms weekly for six weeks; then one room per week for 12 weeks. An audit was designed to monitor for proper handwashing during dressing changes. DON or designee will monitor two dressing changes twice weekly for six weeks; then two dressing changes weekly for six weeks; then one dressing change per week for 12	

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	the hands should be lathered with soap for 20 seconds, gloves should be changed between dirty and clean tasks, and gloves should be changed between touching other items and packing a wound. On 12/4/23 at 4:16 P.M., a current Handwashing/Hand Hygiene policy, dated 9/2022, was provided and indicated "Wash well for 15-20 seconds, using a rotary motion and friction". 3.1-18(b)(1)(A) 3.1-18(l)		weeks. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	
F 9999 Bldg. 00	1.3 Administration and Management Sec. 1.3. (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (D) major accidents. This State Rule is not met as evidenced by: Based on interview and record review, the facility failed to report a fall with major injury to the	F 9999	**F9999** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The Incident Report for Fall with major injury for Resident S was reported to the Indiana Department of Health. The facility has implemented a program for specialized populations (IDDD) with a designated QIDP to head the program. A QIDP review has been completed for each of the three individuals. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:**	01/01/2024

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	Indiana Department of Health (IDOH) for 1 of 8 residents reviewed for falls. (Resident S) Finding includes: On 12/4/23 at 12:55 P.M., Resident S's clinical record was reviewed. The most current annual MDS (Minimum Data Set) Assessment, dated 6/23/23, indicated the resident had mild cognitive impairment. A progress note, dated 9/13/23, indicated "nurse heard resident yelling for help. Found resident sitting on the bathroom floor. Resident has her back leaning against the bathroom door of her neighbor, she has her socks and shoes on. Resident's left leg is overlapping her right leg whichwas [sic] slightly bent. Resident's wheelchair is in front of her. Resident stated she is done using the toilet and about to transfer to her wheelchair, but she slipped. Resident alert. VS (vital signs) were as follows: BP (blood pressure) 126/74 SPO2 (oxygen saturation) 96% at room air, PR (pulse rate) 86 T (temperature) 97.9F (Fahrenheit) RR (respiratory rate) 20. Assisted resident to the wheelchair and noted her right thigh starting to get swollen, no open area, resident on severe pain [sic]. On call MD (medical doctor) notified and gave order to send resident to ER (emergency room). [Name of Ambulance] arrived to the facility at 1905 (7:05 P.M.) and they stated resident has most likely fracture in her right femur. DON (Director of Nursing) and [name of POA] notified. Resident transferred to [name of hospital] @2000 (8:00 P.M.) per stretcher." An IDT (Interdisciplinary Team) Note, dated 9/14/2023, indicated "unwitnessed fall discussed in IDT. Fall with major injury. Sent to ER for eval (evaluation) and tx (treatment)."		Other residents with a fall with major injury have the potential to be affected. All new falls will be reviewed, and a report completed if indicated. Any resident admitted with a diagnosis of ID or DD would have the potential to be affected. The facility has implemented a program for specialized populations (IDDD) with a designated QIDP to head the program. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Department managers have been educated in the IDOH reportable guidelines and the timeline for reporting. Department managers are educated on the need to notify the administrator of any observations or knowledge of anything that meets the guidelines for reporting. IDT met and discussed the need for ID/DD specialized program. The QIDP has done a review of the individuals required and documented program needs. Staff was in-serviced on providing services to a specialized population (ID/DD). **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	155716	A. BUILDING 00 B. WING	12/06/2023

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	A hospital discharge summary, dated 9/15/23, indicated the resident's discharge diagnosis was periprosthetic fracture around internal prosthetic right hip joint. A review of Facility Reported Incidents for September lacked a report of this resident's fall. On 12/5/23 at 9:33 A.M., the Administrator indicated that all resident falls with major injury should be reported to the IDOH within 24 hours from the time of injury. She further indicated that Resident S's fall on 9/13/23 was overlooked and was not reported to the State. On 12/5/23 at 11:46 A.M., the Administrator indicated the facility did not have a specific policy for mandatory reporting, but they followed State regulations. 7-4 Resident programs Sec. 4. (a) The facility shall provide a program for developmentally disabled individuals, which assures the following: (1) There is a designated staff member qualified by a minimum of two (2) years experience with developmentally disabled individuals, or through completion of the council approved training program on developmental disabilities, responsible for the program. This State Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure implementation of a program for specialized populations served in the facility (intellectual and/or developmental disability) for 3 of 3 residents reviewed for Intellectual Disability.		**into place:** An audit was created to monitor the reporting of falls with major injuries. The audit will be completed by DON or designee on all falls five times a week for six months. s Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	

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	Finding includes: On 11/27/23 at 1:37 P.M., the Administrator provided a list of three residents with a diagnosis of intellectual and/or developmental disability. On 12/01/23 at 1:45 P.M., the Administrator indicated the facility currently did not have a program for those residents with an intellectual and/or developmental disability. She indicated the facility did not have a designated Qualified Intellectual Disability Professional (QIDP) to head the program and was aware that one was needed. At that time, she indicated she was unaware if inservices related to the specialized population of residents had been offered. On 12/04/23 at 10:26 A.M., Registered Nurse (RN) 15 indicated she had not received any inservices related to residents with an intellectual or developmental disability. On 12/5/23 at 9:33 A.M., the Administrator indicated she was unable to find any inservices provided to staff related to the specialized population of residents. The Administrator further indicated there was not a policy related to the QIDP, inservices, or program. This citation relates to complaint IN00418710.			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey and Investigation of Residential Complaint IN00417446. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00418710 and IN00421830.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The	

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	This visit was in conjunction with the Investigation of Complaint IN00423065. Residential Complaint IN00417446 - State deficiencies related to the allegations are cited at R0148. Complaint IN00418710 - Federal deficiencies related to the allegations are cited at F585, F622, F689, and F9999. Complaint IN00421830 - No deficiencies related to the allegations are cited. Complaint IN00423065 - Federal deficiencies related to the allegations are cited at F684. Survey dates: November 27, 28, 29, 30, December 1, 4, 5, & 6, 2023 Facility number: 000439 Residential Census: 10 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.		Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey and Complaint survey conducted December 6, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of January 1, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0145 Bldg. 00	410 IAC 16.2-5-1.5(b) Sanitation and Safety Standards - Deficiency (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on observation, record review, and interview, the facility failed to ensure resident safety from accidental hazards inside the facility, proper record keeping and maintenance of equipment, and efficient staffing needed for facility maintenance for 1 of 1 residential units	R 0145	**R145** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:**	01/01/2024

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	observed. Finding includes: On 12/5/23 at 2:30 P.M., the hallway ceiling light between rooms 4 and 5 was observed to be out. The cover was off and there were exposed wires. On 12/5/23 at 2:15 P.M., Resident A indicated the light has been out in the hall for a month. It had been reported to maintenance and they said it needed a new valance. Resident A indicated they sometimes do laundry at night and didn't feel comfortable walking through a dark hall. On 12/5/23 at 8:43 A.M., the Maintenance Director indicated she knew the hallway light was out. The lights were original to the building, and this particular light was no longer available. She further indicated there was no log of maintenance needs, and the staff would leave post-it notes on her office door. She indicated that she used to have a phone application called [name of application] that contained a daily reminder of the maintenance needs of the facility as well as a list of vendors for equipment needs. Once [name of company] took ownership this application was retired and all the information it contained was lost. The new maintenance application had not been installed yet. Due to the deletion of her previous maintenance program application, she was having a hard time finding a vendor to provide parts to fix the light. At that time, she indicated there was not enough staff to handle daily facility maintenance needs and perform daily room checks. On 12/6/23 at 8:28 A.M., the Administrator indicated there was no work order log. The Maintenance Director received requests on sticky		The light between rooms four and five has been repaired. A new system has been implemented to track maintenance work orders and monitor them for completion. Staffing was reviewed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Other residents with unresolved work orders have the potential to be affected. Any requested work orders will be monitored for completion. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance staff has been educated that items while under repair cannot be left with exposed wires. The Maintenance Director has been trained in the process of ordering items for the facility. Maintenance staff have been educated on the TELs system and how to monitor unresolved work orders. Maintenance staff have been educated on the need to keep a written log of work orders received prior to full implementation of the TELs system or if the online system is down. Staff will be educated on the TELs	

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	notes, and then threw them away when she was done. A policy for Environment was asked for and never received. This citation relates to complaint IN00417446.		system and how to initiate work orders in the system, **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** A report is available and will be monitored through the TELs system on the status of work orders. The administrator or designee will monitor the report weekly for six months. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living.			

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	(3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to ensure resident weights were taken at admission and semiannually thereafter for 3 of 7 residents reviewed. (Resident 5, Resident 4, Resident W) Findings include: 1. On 12/6/23 at 11:00 A.M., Resident 5's clinical record was reviewed. Admission date was 10/1/21. The clinical record lacked a weight for the last 12 months. On 12/6/23 at 12:40 P.M., a list of all residential residents' weights for the last 12 months was provided. Resident 5 was not on the list. 2. On 12/5/23 at 2:28 P.M., Resident W's clinical record was reviewed. The resident was admitted on 1/23/23. An admission weight of 133 pounds was recorded. The chart lacked a semiannual weight. 3. On 12/6/23 at 10:13 A.M., Resident 4's clinical record was reviewed. Resident 4 was admitted on 9/15/18. The clinical record lacked documentation of the resident's weight in the last 12 months. On 12/6/23 at 12:40 P.M., a list of all residential residents' weights for the last 12 months was provided. Resident 4 was not on the list.	R 0216	**R216** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** A weight was obtained for residents 5, 4 and W. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Residents in the Residential section of the facility have the potential to be affected. All residents have been weighed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Staff were educated on the requirements to monitor weights upon admission and semi-annually for the residential Residents. All new admissions to residential will be reviewed by the IDT for the presence of an admission weight five times per week in clinical meeting.	01/01/2024

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	On 12/6/23 at 12:50 P.M., the Administrator indicated the facility followed the State regulation for weighing residents.		**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit report will be pulled from PCC monthly by the DON or designee to review for the completion of the semi-annual weights. An audit was created to monitor for the completion of admission weights for any new admissions to residential. DON or designee will complete the audit for all new admissions. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed: January 1, 2024**	