STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155829	A. BUILDING 00 B. WING	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGS AT LAFAYETTE, THE	2402 SOUTH STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: July 13, 14, 17, 18 and 19, 2023. Facility number: 013499 Provider number: 155829 AIM number: 201285490 Census Bed Type: SNF/NF: 22 SNF: 15 Residential: 21 Total: 58 Census Payor Type: Medicare: 8 Medicaid: 20 Other: 9 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed July 25, 2023.	F 0000		
F 0558 SS=E Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record	F 0558	p paraid="1856507691"	09/08/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Thompson	Director of Health Services	08/23/2023

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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	review, the facility failed to ensure a resident was able to have a personal recliner in her room, a resident was allowed to have undisturbed privacy, and a resident was provided adequate access and space for personal clothing for 3 of 3 residents reviewed for room space. (Resident 21, 26 and 3) Findings include: 1. The record for Resident 21 was reviewed on 07/19/23 at 10:24 a.m. Diagnoses included, but were not limited to, dementia with psychotic disturbance, delusional disorders, anxiety disorder, history of falling, presence of a right artificial hip joint, unsteadiness on feet, other lack of coordination, and repeated falls. During an interview, on 07/17/23 at 10:32 a.m., Resident 21 indicated she was admitted to the facility 06/23/2023. The room was small. She was not offered the choice of another room. Her roommate's television set was on the wall of her side of the room. The dresser was at the end of her bed, and she was only able to open drawers halfway. She did not have a closet to hang her clothes, since her roommate used the whole closet. There were no visitor chairs in her room. During an observation of Room 318, on 07/17/23 at 10:32 a.m., the following were observed in Room 318: a. There were 2 residents in the room (Resident 21 and 26). The room had 2 beds, 2 dressers, 2 nightstands, 2 televisions on the wall, 1 double closet, and no visitor chairs. Both residents had wheelchairs. b. The distance of the dresser drawer to the foot of the bed measured 11 inches. c. Resident 21 was not able to access her clothing from the dresser drawers due to the limited space		paraeid="{cd737efb-ddfb-459a-a904-d1664cf94ede}{244}" >F558 Residents 21, 23, and 3 were found to be affected by the stated deficient practice with no negative outcomes. ·All residents have the potential to be affected by the stated deficient practice. ·Education completed for all staff regarding room space for personal belongings, adequate access and space for personal clothing and undisturbed privacy. ·The DPO or designee will review all rooms for space for personal belongings, adequate access and space for personal clothing and undisturbed privacy and will audit 5 rooms a week x4 weeks, 3 rooms a week x4 weeks, 1 room weekly x4 weeks, every other week x4 weeks and 1 room monthly x2 months. As a quality measure, the DPO or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan	

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	between the foot board of bed and the dresser. d. The resident was not able to have a chair in her room. 2. The record for Resident 26 was reviewed on 07/17/23 at 10:22 a.m. Diagnoses included, but were not limited to, major depressive disorder, expressive language disorder, difficulty in walking, cognitive communication deficit, muscle weakness, history of falling, and dependence on a wheelchair. A notice of room transfer, dated 05/30/23 at 9:54 a.m., indicated the resident and resident representative were informed of the room change which would occur on 06/01/23. The reason for the room change was for a facility renovation. The resident was previously in a private room. A progress note, dated 06/02/23 at 4:00 p.m., indicated Resident 26 became tearful when asked how she was liking her room. She expressed dissatisfaction with the room change. During a phone interview, on 07/14/23 at 11:10 a.m., Resident 26's daughter indicated she had concerns over the size of the room. She indicated the resident was not given a choice of another room. Her mother's nightstand and head of the bed were in front of the heating and cooling unit. The dresser was halfway in front of the closet. Her mom's roommate complained about the room size. Before her mom was moved to the new room she had a recliner, which the family brought from home. The recliner was not currently in her mother's room. She asked where the recliner was and had not received an answer from facility. During an interview, on 07/17/23 at 2:25 p.m., the		will be reviewed and updated as warranted.¿ p paraid="745749621" paraeid="{cc7936a7-e8dd-4c75-81ae-6084876a6ef3}{43}" >	

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	Executive Director indicated Rooms 318 and 321 were the same set up. One resident in Room 321 slept in a recliner per preference. They did find Resident 26's recliner. It was placed in storage, and he would notify the daughter. The Executive Director submitted a generic diagram of Room 318. The diagram indicated Room 318 was 194 square feet. The diagram submitted showed 2 beds, 2 dressers, 2 chairs, 2 nightstands, a single closet and 1 wardrobe in the room. Resident 26 was not able to have a recliner in her room even though the diagram showed space for chairs. With the resident's bed, nightstand and dresser in the room, there was not enough space for a personal recliner or a chair. During observations of the rooms on the 300 hall, all rooms had 2 chairs except rooms 321 and 322. Both had 1 chair. The only room on the 300 hall without chairs was room 318. A standard chair measured 3-foot-tall by 2 foot 4 inches wide by 1 foot 8 inches depth from front to back. 3. During a resident council meeting, on 7/17/23 at 2:31 p.m., Resident 3 indicated a lot of the residents did not like being in a two-person room. She had nothing against her roommate (Resident 19) although the roommate made a lot of noise, had to have the light on quite a bit and Resident 3 needed total darkness to sleep. She had to move her wheelchair every time the roommate would come in the room because there was not enough room for both wheelchairs. The record for Resident 3 was reviewed on 7/18/23			

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	at 2:44 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, heart failure, macular degeneration, presence of a cardiac pacemaker and anxiety disorder. A notice of room transfer, dated 5/30/23 at 12:59 p.m., indicated the resident and resident representative were informed of the room change which would occur on 6/1/23. The reason for the room change was for a facility renovation. The resident was previously in a private room. During an interview, on 7/18/23 at 10:49 a.m., Resident 3's daughter indicated there was issues with two people being in the room. Her mom slept in a recliner and when the staff would assist the roommate in or out of her bed the staff had to move her mom's recliner. There was no other place to put the recliner since the television was mounted on the left side of the room and this was where the resident could see it. The resident was not given a choice of rooms. She had asked for the resident not to be in a room at the end of the hallway and the Executive Director indicated he would take this into consideration. The resident was still moved to a room at the end of the hallway. She had to put masking tape on the floor to show where the recliner would go since the staff kept moving the recliner when they assisted Resident 19 and didn't put it back where the resident could see the television. During an interview, on 7/18/23 at 11:16 a.m., LPN 3 indicated Resident 3, and her roommate could not have both of their wheelchairs in the room at the same time as there was not enough space. The staff would have to move Resident 3's chair to be able to get the roommate in the room or out of the room and the staff would not always put the			

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	wheelchair back where Resident 3 could access the chair. Resident 3 was able to transfer herself from the recliner to the wheelchair. The staff could leave the recliner in place they just had to move the wheelchair out of the room to get the Resident 19 in the room. It was rough due to the space in the room. The residents did not get much notice before the room changes and the room changes were due to the facility renovation for a dementia unit. Resident 3 was not able to have undisturbed privacy in her room if the staff were assisting Resident 19. During an observation, on 7/18/23 at 4:00 p.m., the distance from Resident 3's recliner to the roommate's bed was 3 feet and 10 inches. There was a space of 2 feet and 1 inch from the front of the recliner to the right side of the dresser to allow the resident to recline to sleep. A standard wheelchair measures 36 inches tall, 25 inches wide, and 32 inches long. The space of 3 feet and 10 inches between Resident 3's recliner/wheelchair would have to accommodate Resident 19's wheelchair and the two staff who were needed to assist Resident 19 in and out of bed. 4. The record for Resident 19 was reviewed on 7/19/23 at 3:40 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, orthopedic aftercare following surgical amputation, aphasia (loss of ability to speak), and cellulitis of the left lower leg. A care plan, dated 2/1/2019, indicated the resident			

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	was at a risk for falls related to weakness, and right sided hemiplegia. The interventions included, but were not limited to, two staff to assist with transfers and a bariatric bed (a heavy-duty bed designed to comfortably and safely accommodate large individuals) to have more room for the resident to turn. A current policy, titled "Resident Rights Guidelines," dated as revised on 5/11/17 and received from the Clinical Support on 7/19/23 at 1:47 p.m., indicated "...To ensure resident rights are respected and protected and provide an environment in which they can be exercised...Resident shall not leave their individual personalities or basic human rights behind when they move to a health campus...Our residents have a right to...Be treated with dignity and respect...Privacy...Be treated fairly, courteously and with respect by staff...Personalize their apartment..." 3.1-3(v)(1) 3.1-19(f)(5) 3.1-19(k) 3.1-19(m)(4)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.			

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	§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to thoroughly investigate an incident involving a CRCA (Certified Resident Care Assistant) and a resident for 1 of 1 resident reviewed for abuse. (Resident 27) Finding includes: During an interview, on 07/14/23 at 10:10 a.m., Resident 27 indicated shortly after her admission, a CRCA was verbally abusive to her. She indicated the CRCA used foul language, was written up, and fired. The record for Resident 27 was reviewed on 07/17/23 at 2:55 p.m. Diagnoses included, but were not limited to, malignant neoplasm of the brain, sequalae of cerebral infarct, depression, anxiety, and epilepsy. An admission MDS (Minimum Data Set) indicated the resident's BIM's (brief interview for mental status) score was 15 (cognitively intact). A typed document, dated 3/20/23, received from the Director of Health Services indicated the Assistant Director of Health Services spoke with the resident about the incident. The resident was upset over the treatment she had received by the CRCA. She stated the CRCA had not changed her all night and she was left to sit in her urine. She was concerned about other residents who were	F 0610	p paraid="1856507691" paraeid="{cd737efb-ddfb-459a-a904-d1664cf94ede}{244}" > p paraid="745749621" paraeid="{cc7936a7-e8dd-4c75-81ae-6084876a6ef3}{43}" >F610 Resident 27 was affected by the alleged deficient practice with no negative outcomes. ·All residents have the potential to be affected by the stated deficient practice. ·Education for all staff regarding abuse. Leadership educated on abuse investigations. ·ED or designee to audit all allegations of abuse for thoroughness x6 months. As a quality measure, the ED or will review any findings and corrective action at least quarterly and ongoing until campus achieves	09/08/2023

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	unable to speak for themselves. The resident became tearful and indicated the CRCA used the word f*** when she couldn't get the residents blankets in order. The incident made the resident hesitant to use the call light the rest of the night. A resident concern form, dated 3/20/23 at 11:00 a.m., indicated the CRCA had not changed her brief all night. The resident woke up soaked and had to sit in her own urine. The CRCA used foul language which was against policy. The Assistant Director of Health Services indicated she would investigate the allegation and take appropriate action with the CRCA. The resolution on the form was to terminate the CRCA. A personnel action form, dated 3/6/23, indicated the CRCA was suspended due to allegations of poor care and possible neglect. After the investigation, it was determined it was not neglect, but below facility standards. As of 3/6/23, the facility decided to separate employment. There were no resident or staff interviews included in the investigation to indicate residents or staff had been interviewed. During an interview, on 07/17/23 at 3:40 p.m., the resident indicated shortly after her admission to the facility, a CRCA was pulling sheets around on her bed and wasn't getting it quite right. The CRCA said f*** and the resident found the word offensive. The Executive Director, Director of Health Services and Assistant Director of Health Services investigated the incident. She had not seen the CRCA since the incident. During an interview, on 07/17/23 at 3:54 p.m., the Director of Health Services indicated she believed the CRCA involved was terminated for customer		one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.¿ p paraid="1396945959" paraeid="{cc7936a7-e8dd-4c75-81ae-6084876a6ef3}{81}" >	

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	service issues. The resident did not feel intimidated or complain of abuse. The resident was upset about the language. During an interview, on 07/18/23 at 2:15 p.m., the Clinical Support Nurse indicated the 3 forms submitted (typed document with interview of the resident, resident concern form and personnel action form) were the complete investigation. No resident or staff interviews were documented. A current policy, titled "Abuse and Neglect Procedural Guidelines," dated June 2023 and received from the Director of Health Services on 7/20/23 at 3:39 p.m., indicated "...upon identification of suspected abuse or neglect immediately provide for the safety of the resident...suspend suspected employee(s) pending outcome of the investigation...identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations...providing complete and thorough documentation of the investigation...." 3.1-28(d)			
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:			

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	§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.			
	Based on observation, interview and record review, the facility failed to ensure a resident received bathing as scheduled in the months of May and June 2023 for 1 of 1 resident reviewed for ADL (activities of daily living) care. (Resident 27) Findings include: During an observation, on 07/14/23 at 10:13 a.m., the resident was in her bed with the head of the bed elevated and her hair had a greasy appearance.	F 0676	p paraid="1856507691" paraeid="{cd737efb-ddfb-459a-a904-d1664cf94ede}{244}" >F676 ol class="NumberListStyle1 SCXW102341708 BCX0" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;"	09/08/2023

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	The record for Resident 27 was reviewed on 07/17/23 at 2:55 p.m. Diagnoses included, but were not limited to, malignant neoplasm of the brain, acute respiratory failure with hypoxia, type 2 diabetes, acute kidney failure, morbid obesity, sequalae of cerebral infarct, depression, anxiety, and epilepsy. A review of the point of care documentation, dated May 2023, indicated a bath did not occur on 5/11, 5/13, 5/14, 5/29, and 5/30/23. There was no documentation regarding the reason the bath did not occur. The documentation indicated the resident required extensive assistance with shower and partial assistance with a shower. A review of the point of care documentation, date June 2023, indicated a bath did not occur on 6/24, 6/25, 6/26 and 6/27. There was no documentation regarding the reason the bath did not occur. The documentation indicated the resident required extensive assistance with shower and partial assistance with a shower. There was no documentation in the progress notes for the dates the baths did not occur to indicate the reason for the baths not occurring. During an interview, on 7/14/23 at 10:15 a.m., Resident 27 indicated she had not had a bath in a week. She pulled at her hair and stated look at my greasy hair. A staff member came in and ask if she wanted a shower, the resident agreed, and the staff member never returned. A current policy, titled "Caregiver New Hire Checklist," dated 3/20/23 and received from the Director of Health Services on 7/19/23 at 4:13 p.m., indicated "...back care, partial, shower, bed bath...documentation of refusals...."		Resident 27 was affected by the alleged deficient practice with no negative outcomes. All residents have the ability to be affected by the stated deficient practice. All residents were reviewed for bathing schedules. ·Nursing staff were re-educated regarding completion of baths and of documentation in care assist. ·DHS and/or designee will randomly audit 5 residents per week for 4 weeks, then 5 residents every other week for 4 weeks, and then 5 residents a month for 4 months. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance improvement. The plan will be reviewed and updated as warranted. p paraid="1491700618" paraeid="{cc7936a7-e8dd-4c75-81ae-6084876a6ef3}{129}" >	

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	155829	A. BUILDING 00 B. WING	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGS AT LAFAYETTE, THE	2402 SOUTH STREET LAFAYETTE, IN 47904

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	There was no policy for ADL care. 3.1-38(a)(2)(A)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to ensure physician's orders and care plan interventions were followed for 1 of 2 residents reviewed for pressure ulcers. (Resident 10) Finding includes: During an observation, on 7/17/23 at 11:53 a.m., Resident 10 did not have a Prevalon boot (pressure relieving device) on his right foot while his left foot was covered up with a blanket. The record for Resident 10 was reviewed on 7/17/23 at 11:26 a.m. Diagnoses included, but were not limited to, pressure ulcer of left heel, hemiplegia (paralysis) and hemiparesis (weakness)	F 0686	p="" paraid="1856507691" paraeid="{cd737efb-ddfb-459a-a904-d1664cf94ede}{244}"> p="" paraid="1491700618" paraeid="{cc7936a7-e8dd-4c75-81ae-6084876a6ef3}{129}">F686 Resident #10 has the ability to be affected by the alleged deficient practice with no negative outcomes. Resident 10 has had skin assessment completed, all current skin interventions care planned verified in place and orders reviewed for prevention. All residents have the ability to be affected by the	09/08/2023

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	on left side, and muscle weakness. A current care plan, dated 3/3/22, indicated the resident was to have Prevalon boots on his bilateral (both) feet at all times. A physician's order, dated 4/28/23, indicated Prevalon boots were to be on at all times. The MAR (Medication Administration Record) on 7/17/23 indicated the resident had Prevalon boots on although no boots were observed. During an interview, on 07/18/23 at 11:03 a.m., LPN 4 indicated she was unsure if the resident' Prevalon boots were on and if they were not on then they should be put on right away. A current policy, titled "GUIDELINES FOR MEDICAL RECORDS CLIINICAL DOCUMENTATION," received from the Director of Health Services on 7/19/23 at 1:47 p.m., indicated "...Entries in a residents record need complete and are authenticated and dated by the person responsible for ordering, providing, or evaluating the service in a prompt manner. Any corrections to the resident record are made by authorized persons in accordance with acceptable standards of practice...." 3.1-40(a)(2)		alleged deficient practice. All residents' orders for pressure ulcer prevention verified in place, and care plans reviewed for skin care interventions. All staff have been re-educated on skin interventions and pressure injury prevention. MDS educated on pressure ulcer care plans. DHS and/or will complete audits on 5 residents to ensure skin interventions and care plans are in place, weekly x 4 weeks, then 5 residents every other week for 4 weeks, and then 5 residents a month for 4 months. ¿As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance improvement. The plan will be reviewed and updated as warranted. p="" paraid="801727376" paraeid="{cc7936a7-e8dd-4c75-81ae-6084876a6ef3}{169}">	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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	§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 obtain a physician's order and to ensure care plan interventions were in place for the use of a wanderguard monitoring bracelet for 1 of 2 residents reviewed for accidents. (Resident 1) Finding include: During an observation, on 07/17/23 at 10:44 a.m., Resident 1 was sitting in a recliner, in the lounge area, with her feet elevated and her eyes closed. The resident had a monitoring bracelet (used for residents who wander) on her right ankle. During an observation, on 07/18/23 at 10:17 a.m., the resident was sitting in a recliner with her feet elevated and her eyes closed. The resident had a monitoring bracelet intact to her right ankle. The record for Resident 1 was reviewed on 07/14/23 at 3:07 p.m. Diagnoses included, but were not limited to, fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing, and dementia. There was no order in the record for the monitoring bracelet. There was no care plan to indicate the resident had a monitoring device. During an interview, on 07/18/23 at 2:31 p.m., the Director of Health Services indicated there was no order for wanderguard (monitoring bracelet) placement or for checking the function of the	F 0689	ol class="NumberListStyle1 SCXW102341708 BCX0" role="list" start="4" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" F689 ol class="NumberListStyle1 SCXW102341708 BCX0" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" Resident #1 was affected by the alleged deficient practice with no negative outcomes. All residents with wander guards have the ability to be affected. Residents with wander guards were audited, orders verified, and care plans updated. ·Nursing staff educated on wander guard orders and care plans. ·DHS and/or will audit all current residents with wander guards to check placement, and function orders and care plans weekly x4	09/08/2023

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	bracelet. There was no consent for the device and the facility had no policy for the use of a wanderguard. A current policy, titled "Elopement Risk Assessment and Prevention," dated 5/1/2017 and received from the Director of Health Services on 7/19/23 at 1:17 p.m., indicated "...each resident will be assessed for elopement risk upon admission, quarterly and with change in condition...a plan of care will be developed and implemented for each resident identified...facilities with wander alert detection systems should place a wander alert bracelet on the resident...a check will be completed of alarmed doors and individual resident alarms to ensure proper functioning ...." 3.1-45(a)(1)		weeks, every other week x 2 months, and then monthly x 3 months. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance improvement. The plan will be reviewed and updated as warranted. p paraid="1435603673" paraeid="{cc7936a7-e8dd-4c75-81ae-6084876a6ef3}{205}" > ¿	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---			

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	§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to educate the resident and/or the resident's representative about the potential risks of antipsychotic medications for 1 of 5 residents reviewed for unnecessary medications. (Resident 28)	F 0758	p paraid="1856507691" paraeid="{cd737efb-ddfb-459a-a904-d1664cf94ede}{244}" >F758 ol class="NumberListStyle1	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Finding includes: The record for Resident 28 was reviewed on 7/17/23 at 10:09 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, delusional disorder, muscle weakness, psychotic disorder with hallucinations, anxiety disorder, adult failure to thrive, and depression. A physician's order, dated 11/5/22, indicated the resident was taking Risperdal (an antipsychotic) 0.5 milligrams once per day. During a resident first meeting, dated 6/28/23 at 2:10 p.m., the facility indicated a review of medications were conducted with the resident's daughter. The resident first meeting did not include the names of the medications reviewed and did not include if the potential side effects were reviewed. During a family interview, on 7/19/23 at 1:45 p.m., the resident's daughter indicated the facility did not educate her on the current medications and their potential side effects. During an interview, on 7/19/23 at 2:35 p.m., the DHS (Director of Health Services) indicated the facility did not have an informed consent policy. The current Nursing Drug Handbook indicated Risperdal had a black box warning. Older adults with dementia related psychosis treated with antipsychotics were at an increased risk for death. The drug was not appropriate to treat older adults with dementia related psychosis.		SCXW102341708 BCX0" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" were affected. No adverse effects noted. Resident or representative discussed with SSD risks and benefits for high-risk antipsychotic medications. Resident and representative have given consent to administer medications as ordered. All residents who are on high-risk antipsychotic medications have the potential to be affected. Audit completed of all residents that have high-risk antipsychotic medications, ensure that resident and/or representatives are aware of the risk and benefits of high-risk antipsychotic medications. Nurses/SSD to be educated on reviewing risks and benefits of antipsychotic medications with residents or representatives. ol class="NumberListStyle1 SCXW102341708 BCX0" role="list" start="3" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" As a measure of ongoing compliance, the DHS or designee	

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	A current policy, titled "Resident Rights Guidelines," received from the Clinical Support on 7/19/23 indicated "...Be given the information necessary to participate in decisions which affect them individually and corporately...." 3.1-48(a) 3.1-48(a)(6) 3.1-4(c)		will perform audits on residents with antipsychotic medications and were reviewed with resident or representative 5 residents weekly x4 weeks, 3 res a week X 4 weeks, 1 resident a week X 4 weeks, one resident a week every other week and then monthly X 2 months. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance improvement.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: July 13, 14, 17, 18 and 19, 2023. Facility number: 013499 Residential Census: 21 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on July 25, 2023.	R 0000		

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R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure staff met the requirements of Cardiopulmonary Resuscitation (CPR) and First Aid for staffing for 12 of 42 shifts reviewed for COR and First Aid. Findings include: A record review, on 7/19/23 at 3:30 p.m., indicated multiple shifts from 7/7/23 through 7/13/23 were not staffed with CPR and First Aid certified staff. The dates and shifts included were: a. On 7/7/23, No CPR or First Aid coverage for the	R 0117	p paraid="1856507691" paraeid="{cd737efb-ddfb-459a-a904-d1664cf94ede}{244}" > p paraid="1683538947" paraeid="{219559f8-8177-4d82-963c-76bdfef437ad}{8}" >R117 No residents were affected by the alleged deficiency. Facility to	09/08/2023

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	night shift. b. On 7/8/23, No First Aid coverage for the evening shift and night shift. c. On 7/9/23, No First Aid coverage for the day shift, evening shift and night shift. d. On 7/10/23, No CPR or First Aid coverage for the night shift. e. On 7/11/23, No First Aid coverage for the night shift. f. On 7/12/23, No First Aid coverage for the night shift. g. On 7/13/23, No First Aid coverage for the night shift. During an interview, on 7/19/23 at 3:00 p.m., the Clinical Support Nurse indicated they did not have CPR and First Aid certified staff for the above shifts. During an interview, on 7/19/23 at 3:03 p.m., the Director of Health Services indicated they did not have CPR and First Aid coverage for several shifts. A current policy, titled "Assisted Living Staff Training Requirements Guidelines," dated as revised 8/11/2016 and received from the Director of Health Services on 7/19/23 at 4:00 p.m., indicated "...To ensure the staff caring for residents has the necessary training and knowledge to meet the needs of the residents...Prior to working independently staff shall receive orientation and training which shall include but may not be limited to: First aid - either a Red Cross class or training by a licensed registered nurse for all staff in applicable states...CPR in applicable states...."		ensure at least one person per shift to be first aid trained certified.¿ ·is in the process of identifying and obtaining the employees' first aid training certifications. ol class="NumberListStyle1 SCXW102341708 BCX0" role="list" start="3" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" schedule will be audited daily to ensure one is first aid trained certified and for 4 weeks initially.¿ As a measure of ongoing compliance from audits it 3 times a week for another 4 weeks, once a week for 4 weeks, every other week for another 4 weeks, and monthly for another 3 months.	
R 0298	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency			

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Bldg. 00	(2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.			
	Based on observation, interview and record review, the facility failed to verify controlled substance counts for 1 of 1 medication carts observed. Findings include: During a medication storage observation, on 7/17/23 at 10:45 a.m., the medication cart had missing signatures for the controlled drug count sheets on July 2, 14 and 16, 2023 to confirm two nurses had verified the controlled substance count. During an interview, on 7/17/23 at 10:45 a.m., the Director of Assisted Living (DAL) indicated if a Certified Registered Medical Aide (CRMA) worked they do not count the narcotics and do not sign the narcotic count sheets. The count sheets do not get signed when a CRMA works. The DAL indicated she normally worked the next day and would sign the narcotic sheets. The nurses should sign the controlled drug count sheets with two nurses at each shift change.	R 0298	p paraid="1856507691" paraeid="{cd737efb-ddfb-459a-a904-d1664cf94ede}{244}" >R298 ol class="NumberListStyle1 SCXW102341708 BCX0" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" Narcotic logbooks reviewed to ensure that narcotic medications are being counted and signed on shift and off shift All residents have the potential to be affected by the alleged deficient practice. ol class="NumberListStyle1 SCXW102341708 BCX0"	09/08/2023

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SPRINGS AT LAFAYETTE, THE	2402 SOUTH STREET LAFAYETTE, IN 47904

(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
	During an interview, on 7/19/23 at 3:45 p.m., the Clinical Support Nurse indicated the narcotic count should be signed by both nurses. During an interview, on 7/19/23 at 3:46 p.m., the Director of Health Services indicated the controlled substance count should be completed between the oncoming nurse and outgoing nurse with signatures from each nurse. A current policy, titled "Guidelines for Narcotic Count," dated 8/2/2016 and received from the Director of Assisted Living on 7/13/23 at 11:00 a.m., indicated "...Each controlled drug shall have a corresponding count sheet to track distribution. The narcotic book shall contain a sheet providing space for the off going and oncoming nursing staff to record their signature indicating the narcotics has been reviewed...The count will be updated by two nurses to validate the changes with initials and date, as other items are added or removed...Both staff members shall sign the narcotic count is accurately reconciled...Should the available medications not match the count sheets the Director of Health Services shall be notified...."		role="list" start="3" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" All med passers narcotic count policy. As a measure of ongoing compliance, the DHS or designee will complete an audit to ensure narcotics are counted per policy. Said audit will include 5 times weekly x4 weeks to ensure medications are stored per policy three times weekly for 4 weeks, then weekly for 4 weeks, then monthly x3. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance improvement. The plan will be reviewed and updated as warranted.	