STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155481	A. BUILDING 00 B. WING	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR TRACE HEALTH & LIVING COMMUNITY	3701 HODGIN RD RICHMOND, IN 47374

(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: May 8, 9, 10, 13, 14, and 15, 2024 Facility number: 000455 Provider number: 155481 AIM number: 100291010 Census Bed Type: SNF/NF: 83 SNF: 11 Residential: 24 Total: 118 Census Payor Type: Medicare: 17 Medicaid: 65 Other: 12 Total: 94 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 21, 2024	F 0000	**This plan of correction is to serve as Arbor Trace's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **Arbor Trace respectfully requests a desk review for these deficiencies.**	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure residents were clinically appropriate to self-administer	F 0554	**F554 Resident Self-Admin Meds-Clinically Appropriate CFR(s):483.10(c) (7)**	06/11/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shelli Ross	RN/HFA	05/30/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	medications for 3 of 3 residents randomly observed with medications at the bedside. (Resident 2, 9, and 22) Findings include: 1. An observation conducted of Resident 2's room, on 5/8/24 at 3:18 p.m., of a labeled bottle that contained benzocaine. Resident 2 indicated she utilized the benzocaine for her sore gums. An observation conducted of Resident 2's room, on 5/10/24 at 10:48 a.m., of a labeled bottle that contained benzocaine. There was also a bottle of nasal spray. Resident 2 indicated she took the nasal spray at night. Her jaw had been hurting for a while and the benzocaine did help. The clinical record for Resident 2 was reviewed on 5/10/24 at 12:17 p.m. The diagnoses included, but were not limited to, herpes viral encephalitis, altered mental status, and mild cognitive impairment. There were no self-administration assessments for Resident 2's utilization of benzocaine and/or the nasal spray on 5/8/24. A progress note, dated 5/9/24 at 5:08 p.m., indicated the following, "...During the residents care conference...Also resident has been having c/o [complaints of] jaw/teeth pain new orders for Hurricane gel and may have at bedside and self admin. [administer]...." A physician order, dated 1/8/24 and discontinued on 5/9/24, was noted for benzocaine gel every 4 hours as needed for jaw pain. There were no instructions on the order that indicated Resident 2 was to self-administer the medication.		**I. Medications at the bedside were removed from resident 2, 9 and 22 at the time they were discovered during the survey.** **II. Residents have the potential to be affected by the alleged deficient practice. Each room was inspected during the survey and any issues that were identified were corrected at that time.** **III. Education was provided to nursing staff related to medications at the bedside. The systemic change includes the charge nurse will be responsible to ensure residents with medications at the bedside have an assessment, physician's order and care plan to support the safety of this practice.** **IV. The DON/Designee will randomly audit 5 resident rooms to ensure medications are not present at the bedside unless there is a supporting assessment, physician's order and care plan. This will occur 7 days per week on all shifts for 4 weeks then monthly for 11 months to total 12 months of monitoring. Results of audits will be reported to the QA Committee monthly to assist with additional**	

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	2. An observation conducted of Resident 9's room, on 5/10/24 at 10:52 a.m., of 2 lidocaine patches, unopened, and located on the table past the doorway into her room. The clinical record for Resident 9 was reviewed on 5/13/24 at 1:37 p.m. The diagnoses included, but were not limited to, congestive heart failure and arthritis. There was no self-administration assessment in Resident 9's clinical record. 3. An observation conducted of Resident 22's room, on 5/8/24 at 3:06 p.m., of a nasal spray located on the window. An observation conducted of Resident 22's room, on 5/9/24 at 10:19 a.m., of a nasal spray located on the window. The clinical record for Resident 22 was reviewed on 5/13/24 at 1:56 p.m. The diagnoses included, but were not limited to, nasal congestion and edema. There were no self-administration assessments conducted for Resident 22's nasal spray. A physician order, dated 2/14/24, indicated the use of Flonase nasal spray; 1 spray in each nostril daily as needed. An interview conducted with the DON, on 5/14/24 at 4:24 p.m., indicated a self-administration assessment was to be conducted for the residents to determine their ability to self-administer medications and have them at the bedside. A policy titled "Beside Medications and		**recommendations if necessary.** **COMPLIANCE DATE: 6/11/2024**	

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	Self-Administration of Medications", undated, was provided by Clinical Specialist on 5/13/24 at 11:49 a.m. The policy indicated the following, "...Each resident who desires to self-administer medication will be permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility...." 3.1-11(a)			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social,			

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	religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review, the facility failed to obtain a resident's preference for bathing frequency for 1 of 1 resident reviewed for choices. (Resident 24) Findings include: The clinical record for Resident 24 was reviewed on 5/8/24 at 12:04 p.m. Her diagnoses included, but were not limited to: dementia, mood disorder, psychotic disorder with delusions, and anxiety. She resided on a secured unit of the facility. The ADL (activities of daily living) care plan, last reviewed/revised 4/23/24, indicated Resident 24 was unable to independently perform late loss ADLs related to weakness and debility. The 10/19/22 care plan, last reviewed/revised 4/23/24, indicated Resident 24 was cognitively impaired and unable to voice preferences regarding ADLs (activities of daily living.) The goal was for her to have her needs met. An approach, with a start date of 10/19/22 and end date of 6/1/24, read, "Resident unable to state bathing preference. To be offered shower, per facility shower schedule. Staff to observe for any indication that resident may prefer to have shower done at another time of day and to inform IDT [Interdisciplinary Team] if this occurs." The 3/13/24 Quarterly MDS (Minimum Data Set) assessment and 4/20/24 Quarterly MDS assessment both indicated Resident 24 was cognitively intact. An interview was conducted with Resident 24 on	F 0561	**F561 Self-Determination CFR(s) 483.10(f)(1)-(3)(8)** **I. Resident 24 has had her care plan updated to address her shower preferences.** **II. Residents that receive staff assistance for showering have the potential to be affected by the alleged deficient practice. All residents that receive staff assistance for showers have been reassessed for their preferences and their care plans have been updated to reflect their preferences.** **III. Education was provided nursing staff on assessing bathing preferences upon admission. Education has ben provided to social services to determine bathing preferences when completing the social history and again during quarterly care plan conferences. The systemic change includes the nursing administration team will audit all new admissions to determine showering preferences are completed with the admission assessment. In addition social services will review preferences with each quarterly care plan.**	06/11/2024

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	5/8/24 at 12:05 p.m. She indicated she would like to receive showers every other day, but didn't receive them that often in the facility. An interview was conducted with SSD (Social Services Director) 10 on 5/10/24 at 1:47 p.m. He indicated they discussed a resident's preference for bathing frequency upon admission and at care plan meetings. Nursing kept track and there were care plans for "specific out of the norm" preferences. The 10/26/20 Social History Assessment was reviewed. There was a section to document the resident's method of bathing as an adult to include type, frequency, day, etc. The response section was left blank, not completed. The 1/26/24 care conference observation did not reference Resident 24's bathing frequency preference. An interview was conducted with SSD 10 on 5/10/24 at 2:45 p.m. He referenced Resident 24's 10/19/22 cognitively impaired and unable to voice preferences regarding ADLs care plan and indicated he was unaware of any documentation or verification that Resident 24's bathing frequency preference was obtained. On 5/10/24 at 12:53 p.m., the DON provided Resident 24's shower sheets from April 1, 2024 to present. They included sheets for the following dates: 4/1/24, 4/4/24, 4/8/24, 4/11/24, 4/15/24, 4/18/24, 4/22/24, 4/25/24, 4/29/24, 5/2/24, 5/6/24, and 5/9/24. These dates indicated Resident 24 was provided showers twice weekly on Mondays and Thursdays. An interview was conducted with the DON		**IV. The DON/Designee will review all new admissions to determine their showering preferences are determined. This will occur 5 days per week during morning clinical meeting for 4 weeks then monthly for 11 months to total 12 months of monitoring. Results of audits will be reported to the QA Committee monthly to assist with additional recommendations if necessary** **COMPLIANCE DATE: 6/11/2024**	

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	(Director of Nursing) on 5/13/24 at 11:01 a.m. She indicated bathing frequency was generally discussed and documented on admission, but that process was not in effect when Resident 24 was admitted in 2020. It was also discussed at care plan meetings, but she was unsure if social services was specifically documenting bathing frequency preferences at care plan meetings. This morning, the DON spoke with Resident 24 herself, at which time Resident 24 informed she'd like a shower every other day. She was unsure as to the accuracy of the care plan that indicated Resident 24's preferences were unable to be obtained. An interview was conducted with CNA 12 on 5/14/24 at 2:13 p.m. She indicated she spoke with Resident 24 about her shower schedule over the weekend. Resident 24 informed her she would like 3 showers a week in the morning. The Resident Rights policy was provided by the CS (Clinical Specialist) on 5/13/24 at 11:49 a.m. It read, "Federal and state laws guarantee certain basic rights to all residents of our community. These rights include the resident's right to: ...5. Self-determination; ...37. Receive care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. 38. Receive care in accordance with personal preference." 3.1-3(u)(1)			
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment,			

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	including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on interview and observation, the facility failed to promote a clean and homelike	F 0584	**F584 Safe/Clean Comfortable/Homelike**	06/11/2024

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	environment for 1 of 4 residents reviewed (Resident 37) and 2 of 5 units reviewed for a clean and homelike environment. Findings include: The clinical record for Resident 37 was reviewed on 5/14/2024 at 1:22 p.m. The medical diagnosis included dementia with behaviors. An annual minimum data set assessment, dated 1/28/2024, indicated that Resident was cognitively intact. An interview and observation on 5/8/2024 at 11:45 a.m. indicated that the baseboard strip from the door to the kitchenette cabinets was missing. Resident 37 stated that it had been missing for a while. An observation on 5/8/2024 at 12:03 p.m. indicated that along the handrails on the 300 hall, debris was noted to include general debris in the inside corners of the handrails, paper wrappers from straws, a dead insect, and a paper clip. An observation on 5/9/2024 at 10:45 a.m. indicated a thumb tack inside the handrails on the 200 hall. An observation and interview on 5/10/2024 at 2:00 p.m. indicated the general debris in the 300 hall handrails remained. Housekeeper 8 cleaned some debris from the handrails and indicated that it is part of the assignment to clean the handrails weekly, but sometimes when they are cleaning them that the debris gathers in the corners and not everyone "cleans it all out". An observations on 5/14/2024 at 2:30 p.m. with DON indicated that the baseboard stripping in		**Environment CFR(s): 483.10 (i) (1)-(7)** **I. The baseboard strip for the kitchenette's cabinet in resident 37 room was replaced during the survey. All other rooms have been inspected with any noted missing baseboards being replaced. The debris is the handrails was removed at the time it was reported during the survey. All other handrails were inspected with any issues identified being corrected at that time.** **II. Resident rooms and handrails have the potential to be affected by the alleged deficient practice. Any identified issues have been corrected.** **III. Education was provided to the housekeeping staff on reporting missing baseboards and the cleaning of handrails. The systemic change includes the housekeeping supervisor will be responsible for inspecting the handrails for debris during his morning and afternoon rounds of the building. In addition, he will verify rooms have baseboards in place as he rounds the community.** **IV. The Housekeeping**	

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	Resident 37's room was still missing. A policy entitled, "Quality of Life - Homelike Environment", was provided by the DON on 5/14/2024 at 2:45 p.m. The policy indicated, " ...Residents are provided with a safe, clean, comfortable and homelike environment ..."		**supervisor will audit 5 random residents' rooms for baseboards. He will also review facility handrails are clean and free of debris. This will occur twice a day for 5 days a week then weekly for 4 weeks then monthly for 11 months to total 12 months of monitoring. Results of audits will be reported to the QA Committee monthly to assist with additional recommendations if necessary.** **COMPLIANCE DATE: 6/11/2024**	
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 accuracy of a resident's MDS (Minimum Data Set) assessment for 1 of 1 resident reviewed for dialysis. (Resident 50) Findings include: The clinical record for Resident 50 was reviewed on 5/13/24 at 10:22 a.m. The diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis. A dialysis care plan, dated 2/14/24, indicated Resident 50 received hemodialysis due to end stage renal disease.	F 0641	**F641 Accuracy of Assessments CFR(s): 483.20(g)** **I. Resident 50 has had a modification of the MDS to reflect dialysis.** **II. Residents with dialysis have the potential to be affected by the alleged deficient practice. All dialysis residents have had their MDS reviewed and any identified issues have been corrected. Any identified issues have had a modification to the MDS.**	06/11/2024

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	A physician order, dated 3/13/24, indicated Resident 50 received dialysis. A Significant Change Minimum Data Set (MDS) assessment, dated 2/16/24, indicated no dialysis being marked. An interview conducted with the Director of Nursing (DON), on 5/14/24 at 4:24 p.m., indicated the MDS Coordinator conducted the significant change MDS assessment due to Resident 50 starting dialysis. She was unsure why it was not marked on the MDS assessment.		**III. Education was provided to n on accurately coding for dialysis. The systemic change includes the nursing administration team will audit all dialysis admissions to determine their MDS is coded correctly for dialysis.** **IV. The DON/Designee will review all new dialysis residents to determine their MDS is coded correctly for dialysis. This will occur 5 days per week during morning clinical meeting for 4 weeks then monthly for 11 months to total 12 months of monitoring. Results of audits will be reported to the QA Committee monthly to assist with additional recommendations if necessary.** **COMPLIANCE DATE: 6/11/2024**	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2)			

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

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ARBOR TRACE HEALTH & LIVING COMMUNITY	3701 HODGIN RD RICHMOND, IN 47374

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	comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to develop care plans for diabetic medications, antiplatelet medication, medication used to aid in sleep, and gastroesophageal reflux disease (GERD) medication for Resident 53, failed to implement a care planned intervention of care in pairs for Resident 53, and failed to develop a care plan for Resident 89's impaired communication. This deficient practice affected 2 of 24 residents reviewed for care planning. Findings include: 1. The clinical record for Resident 53 was reviewed on 5/14/2024 at 1:20 p.m. The medical diagnoses included diabetes, congestive heart failure, insomnia, GERD, and restless leg syndrome. A Quarterly Minimum Data Set Assessment, dated 3/5/2024, indicated that Resident 53 was cognitively intact. A care plan, dated 12/14/2023, indicated that Resident 53 was to be a care in pairs for all care provided. An interview with Resident 53 on 5/14/2024 at 11:00 a.m. indicated that since yesterday when she raised a concern with her care that they have been utilizing care in pairs with her. She stated prior to 5/13/2024, the facility did not utilize care in pairs. When asked about a concern related to a lab draw on 5/11/2024, Resident 53 indicated that only one staff member was present during that time. An interview with DON on 5/14/2024 at 11:30 a.m. indicated that she obtained the lab draw on	F 0656	**F656 Development/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)** **I. Care plans for resident 53 for diabetic medications, antiplatelet medications, medications used to aid in sleep, and GERD medications were developed during the survey. The staff member involved in not providing care in pairs for resident 53 was educated about following the care plan for care in pairs during the survey. A care plan for communication for resident 89 was developed during the survey.** **II. Residents with diabetic medications, antiplatelet medications, GERD medications, medications used to aid in sleep, care in pairs intervention and communication deficits have the potential to be affected by the alleged deficient practice. Care plans have been reviewed and updated.** **III. Education was provided to MDS staff about development of care plans. The systemic change includes new**	06/11/2024

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	5/11/2024. She indicated that she did not utilize care in pair with Resident 53 due to having a good report with her. A physician order, dated 5/2/2024, indicated Resident 53 to receive medication for treatment of restless leg syndrome. A physician order, dated 5/2/2024, indicated Resident 53 to receive medication for treatment of her insomnia. A physician order, dated 5/2/2024, indicated Resident 53 to receive an oral medication for treatment of her diabetes melilites. A physician order, dated 5/2/2024, indicated for Resident 53 to receive an injectable medication for treatment of her diabetes mellitus. A physician order, dated 5/2/2024, indicated for Resident 53 to receive antiplatelet medications for treatment of her chronic heart failure. A physician order, dated 5/2/2024, indicated Resident 53 to receive medication to treat her GERD. Care plans for the aforementioned medications for Resident 53 were provided by the DON on 5/15/2024 at 12:50 p.m. The provided care plans were dated and/or revised on 5/15/2024. 2. The clinical record for Resident 89 was reviewed on 5/8/24 at 12:15 p.m. His diagnoses included, but were not limited to, expressive language disorder. The 3/28/24 nurse's note indicated he was admitted to the facility for stroke and left sided weakness. He was non-verbal and used a		**admissions will be audited for development of medication specific care plans and impaired communication care plans. Education provided to nursing staff about following the care plan. Education will be provided upon hire and annually regarding following the care plan.** **IV. The DON/Designee will review new admissions to ensure medication specific care plans and communication deficits care plans are developed. Audits will be completed daily, 5 days per week for 4 weeks then monthly. Thereafter, totaling 12 months. The DON/Designee will also audit via direct observation residents who have an intervention on their care plan for care in pairs to determine this intervention is being followed. This auditing will occur daily, 5 days per week for 4 weeks then monthly thereafter totaling 12 months of monitoring. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **COMPLIANCE DATE: 6/11/2024**	

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	communication board. The 4/1/24 Admission MDS (Minimum Data Set) assessment indicated he had unclear speech. An observation of Resident 89 was made on 5/8/24 at 12:22 p.m. He was not able to communicate verbally, but laughed, grunted a bit, and gave the thumbs up. He did not have a communication board, note pad, or anything else visible in his room to use for communication. Resident 89 did not have a communication care plan. An observation of Resident 89 in the activity room was made on 5/14/24 at 10:44 a.m. during a craft activity. A staff member informed him his project looked good and asked if he'd like to add anything else to it. Resident 89 shook his head no, grunted a bit, and waved his hand over his project. No communication board was observed for use with Resident 89 at this time. An interview was conducted with CNA (Certified Nursing Assistant) 13 on 5/13/24 at 2:09 p.m. She indicated she only worked with Resident 89 once the previous day. She assisted him with getting off the commode. He pressed his call light for help and cued to her by pointing to his bottom and moaning. An interview and observation was conducted with CNA 12 on 5/14/24 at 2:15 p.m. in Resident 89's room. Resident 89 was not in his room at this time. CNA 12 indicated Resident 89 had a communication board and picked it up from the night stand near his bed. There were multiple laminated pages with pictures of various objects on each page. CNA 12 indicated, to her			

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	knowledge, he didn't really use it, but it was usually located on his bedside table. An interview was conducted with SSD (Social Services Director) 10 on 5/14/24 at 2:29 p.m. He indicated the Veterans Affairs was working on getting an I-Pad for Resident 89. He was unsure if he should have a care plan regarding his communication, but there were a few other residents on another unit with expressive problems and they all had care plans. An interview was conducted with SSD 10 on 5/14/24 at 3:13 p.m. He indicated Resident 89 did not have a communication care plan. The Comprehensive Care Plans policy was provided by the CS (Clinical Support) on 5/13/24 at 11:49 a.m. It read, "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident....Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; c. Build on the resident's strengths; ...g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; ...i. Reflect currently recognized standards of practice for problem areas and conditions." 3.1-35(a)			
F 0684 SS=E 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			

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	comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure physician notification of a 3-pound (lb.) weight gain over a 24-hour period for 1 of 1 resident reviewed for edema (Resident 9) and 1 of 1 resident reviewed for dialysis (Resident 50). The facility failed to ensure ACE wraps were applied as ordered for 1 of 3 residents reviewed for pressure ulcers. (Resident 11) The facility failed to administer creams to a skin impairment without compounding medicated creams for 1 of 3 residents reviewed for skin impairments (Resident 33). The facility failed to verify a urinalysis was reordered after the results of a probable contamination, ensure vancomycin was given as ordered, and had no verification of catheter care being provided for eight days after return from a hospitalization for 1 of 3 residents reviewed for urinary tract infection (Resident 58). Findings include: 1. The clinical record for Resident 9 was reviewed on 5/13/24 at 1:37 p.m. The diagnoses included, but were not limited to, congestive heart failure, edema, and weakness. A care plan for nutrition, dated 3/26/22, indicated history of weight loss and diuretic therapy. The approach was listed to monitor/record weights and notify the physician of any significant changes.	F 0684	**F684 Quality of Care CFR(s): 483.25** **I. The physician of residents 9 and 50 were notified of the weight changes in April and May during the survey. Resident 11 is wearing ACE wraps as ordered. Resident 33 is receiving her treatment to her sacrum as ordered without compounding medicated creams. Education with the staff member was completed during the survey. Resident 58 has completed anti-biotic treatment. Her MD was notified of the medication error and the urinalysis follow up during the survey with no new orders received. She is receiving documented foley catheter care.** **II. Residents that have daily weights ordered have the potential to be affected by the alleged deficient practice and have been reviewed for physician notification from the past 30 days. Residents with orders for ACE wraps have been reviewed to determine they are being applied as**	06/11/2024

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	A physician order, dated 2/25/24, indicated daily weights to be obtained and contact the physician if more than 3 lbs. of weight gain within one day and/or more than 5 lbs. of weight gain within a week. The electronic medication administration record (EMAR) for April and May of 2024 were reviewed. The following date(s) were noted to where Resident 9 had weight gain of more than 3 lbs. over one day without physician notification located in the clinical record: 4/12/24 of 3.2 lbs., 4/25/24 of 3.4 lbs., 5/4/24 of 5.4 lbs., & 5/9/24 of 3.1 lbs. 2. The clinical record for Resident 50 was reviewed on 5/13/24 at 10:22 a.m. The diagnoses included, but were not limited to, end stage renal disease, edema, and congestive heart failure. A care plan for fluid volume, dated 2/17/21, indicated Resident 50 was at risk for fluid volume excess/exacerbation related to congestive heart failure. The approach was listed to assess and report fluid excess like weight gain. A physician order, dated 3/13/24, indicated daily weights to be obtained and contact the physician if more than 3 lbs. of weight gain within one day and/or more than 5 lbs. of weight gain within a week. The electronic medication administration record (EMAR) for April and May of 2024 were reviewed. The following date(s) were noted to where Resident 50 had weight gain of more than 3 lbs. over one day without physician notification		**ordered. Residents with orders for combination of creams to be applied have been reviewed to determine the creams are not being compounded by nursing staff. Residents with foley catheters have been reviewed to determine they have an order for foley catheter care. Residents with antibiotic orders for the past 30 days have been reviewed to determine physician's orders have been followed. Any identified issues have been reported to the physician and any new orders followed.** **III. Education was provided to nursing staff regarding the policy for notification of weight change and following parameters per order, application of ACE wraps per order, application of 2 or more creams requiring compounding, verification of reordering of a urinalysis after the results of probable contamination, administration of antibiotic medication per order and verification of catheter care orders for residents with foley catheters. Education will be provided upon hire and annually.** **IV. The DON/Designee will audit 5 residents with daily**	

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	located in the clinical record: 4/7/24 of 6.4 lbs., 4/9/24 of 5.3 lbs., 4/11/24 of 3.2 lbs., 4/17/24 of 3.3 lbs., 5/3/24 of 3 lbs., & 5/6/24 of 12.9 lbs. A policy titled "Change in a Resident's Condition or Status", revised April 2007, was provided by the DON on 5/14/24 at 9:20 a.m. The policy indicated the following, "...Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status...e. A need to alter the resident's medical treatment significantly...i. Instructions to notify the physician of changes in the resident's condition...." 3. The clinical record for Resident 11 was reviewed on 5/10/24 at 11:51 a.m. The diagnoses included, but were not limited to, Parkinson's disease, edema, pain, and weakness. A physician order, dated 3/26/24, indicated the use of ACE wraps on in the morning and off at night. An observation conducted of Resident 11, on 5/9/24 at 10:55 a.m., of being up in his wheelchair during an activity. He was wearing nonskid socks but no ACE wraps. An observation conducted of Resident 11, on 5/10/24 at 10:54 a.m., of being up in his wheelchair during an activity. He was wearing tennis shoes and did not have ACE wraps.		**weights for notification of weight change per order, residents with orders for ACE wraps to ensure MD order is followed, residents with orders for 2 or more creams to ensure creams are not being compounded, residents with urinalysis results of probable contamination to ensure reorder of urinalysis, residents on antibiotics to ensure medications are administered per order and residents with Foley catheters have orders for catheter care. Audits will occur daily 5 days per week for 4 weeks then monthly thereafter totaling 12 months of monitoring. The auditing through direct observation will occur with 5 residents daily per week for 4 weeks then monthly thereafter totaling 12 months of monitoring. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **COMPLIANCE DATE: 6/11/2024**	

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	An interview conducted with the Director of Nursing (DON), on 5/14/24 at 4:24 p.m., indicated the expectations are to follow the physician orders as written and notify the physician when it's indicated. 3.1-37(a) 4. The clinical record for Resident 33 was reviewed on 5/10/2024 at 11:30 a.m. The medical diagnosis included Alzheimer's disease. A Quarterly Minimum Data Set Assessment, dated 3/8/2024, indicated that Resident 33 was independent with choices of his daily living, needed assistance of staff for dressing and hygiene needs, and had skin impairments. A physician order, dated 5/9/2024, indicated for Resident 33 to have Silvadene cream applied to sacrum twice a day. A physician order, dated 5/9/2023, indicated for Resident 33 to have nystatin-zinc-triamcinolone topical cream applied to sacrum twice a day. An interview with LPN 9 on 5/14/2024 at 10:50 a.m. indicated that Resident 33 had a skin impairment to his bottom and utilized two creams to the area. She showed the two topical creams in separate containers then stated that when she applied them, she would mix them together in her glove and then apply them to his sacrum. An observation on 5/14/2024 at 11:00 a.m. indicated that LPN 9 provided wound care to Resident 33's sacrum. During this observations, she took nystatin-zinc-triamcinolone cream from one container and then Silvadene from another, mixed the two creams together in her gloved hand then applied the compounded mixture to Resident			

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	33's sacrum. An interview with the Clinical Specialist on 5/14/2024 at 2:10 p.m. indicated that the facility did not have policy about compounding medications at the bedside, but she had reached out to their consulting pharmacist. The consulting pharmacist had directed that one medicated cream should be applied and then the second should be applied on top of the first cream's application, but they should not be mixing the creams prior to application. An interview with the Clinical Specialist on 5/14/2024 at 3:35 p.m. indicated upon additional conversation with the consulting pharmacist that there is no adverse reaction to mixing the creams, but the pharmacy could not fully compound the ingredients into a single cream due to the fully compounding cream of nystatin-zinc-triamcinolone and Silvadene would affect billing. 5. The clinical record for Resident 58 was reviewed on 5/9/24 at 11:15 a.m. Her diagnoses included, but were not limited to, chronic kidney disease, congestive heart failure, hypertension, and diabetes mellitus type II. An interview was conducted with Family Member 20 on 5/8/24 at 2:00 p.m. She indicated Resident 58 had a fall with fracture on 4/7/24. She came to see Resident 58 a few days later and her oxygen saturations were low, so she insisted she be sent to the emergency room. The 4/7/24, 7:27 a.m. nurse's note read, "CNA [Certified Nursing Assistant] observed resident sitting in front of her wheelchair on the hallway floor, this nurse and CNA took residents vitals and assisted back into wheelchair. This nurse asked the resident what they were doing, resident			

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	said she was going to "stand up because she wanted to" resident is visibly confused, has required redirection most of the evening prior to this incident. Resident stated that she wanted to stand, there were "girls in her room" and her legs hurt, she said they would not support her anymore. This nurse took residents vitals : 209/75 [blood pressure,] 16 [respiration rate,] 113 [pulse rate,] 98% RA [oxygen saturation on room air,] 97.3 [temperature,] resident denies pain, no visible injuries, resident states she did not hit her head, residents daughter, and [name of provider] contacted." The 4/7/24, 9:45 p.m. nurse's note read, "Granddaughter - [name of granddaughter] - called expressing concern over her grandmother and requested on call to be contacted [Name of provider] contacted order for UA&CS [urinalysis & culture & sensitivity] and to call urologist and inform him of change in condition. Urine obtained via straight cath [catheter,] urine is cloudy, sediment noted and foul odor. Collection cup and tubes labelled [sic] and placed in REV specimen refrigerator. Granddaughter called back and informed of orders." The 4/8/24, 10:09 a.m. IDT (Interdisciplinary Team) Post Fall Assessment note read, "Fall on 04/07/2024: Resident was observed on floor in hallway close to power chair. Resident stated she was trying to "stand up" prior to fall. Staff last saw resident in her room in her wheelchair. Vital signs and neuro [neurological] checks were initiated. No injuries noted at time of fall. Root cause of fall is that resident was attempting to independently transfer from wheelchair to power chair. Resident has had a noted change in lethargy and weakness. Immediate intervention was to assist resident back in to wheelchair and			

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	start 15 minute checks. Intervention initiated by IDT is to complete labs and UA/C&S [urinalysis/culture & sensitivity] per MD orders r/t [related to] increase in weakness. Care plan updated." The 4/8/24, 1:15 p.m. nurse's note read, "Seen by NP [nurse practitioner] N/O [new order] for labs UA & xRAYS D/T [due to] new ONSET of weakness LAbs & UA obtained this am Xray of back over the weekend were neg [negative] continues on Neuro's d/t recent fall denies any new issues Grand daughter updated." The 4/9/24, 10:25 a.m. physician note indicated Resident 58 was being seen today for increased confusion, being found on the floor by a member of the facility's staff and to review and address, if necessary, any recent labs or diagnostic testing. It read, "Confusion...4/9/24-blood work is nonacute. Urinalysis is pending. Continue supportive treatment. Monitor for problems." The 4/11/24, 7:49 p.m. nurse's note read, "Res [Resident] resting in recliner. Res was previously at bingo Alert and oriented with no distress noted." The 4/11/24, 10:27 a.m. UA/C&S results indicated the specimen was received in the lab on 4/9/24 at 4:23 p.m. She flagged positive with a result of 2+, MODERATE for leukocytes and abnormal amounts of blood and protein in urine. The microbiology report at the bottom indicated there was growth in the urine at 48 hours that was greater than 3 colony types isolated suggesting probable contamination. It read, "If clinically indicated, recollection using a method to minimize contamination, with prompt transfer to urine culture transport tube is recommended."			

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	There was no information in the clinical record to indicate another UA/CS was completed after the above 4/11/24 results. The 4/11/24, 3:44 p.m. NP note, recorded as a late entry on 5/14/24 at 3:45 p.m. and electronically signed by NP 15's Medical Scribe, included the 4/9/24 UA results, but did not include a comment on their review or plan to address the results. An interview was conducted with NP (Nurse Practitioner) 15 on 5/14/24 at 10:39 a.m. She indicated it looked to her like the 4/11/24 UA/CS results for Resident 58 were contaminated, so she did not move forward with treatment because of that. Typically speaking, if there was a contaminated UA and the resident was not symptomatic, then she wouldn't order a follow up UA. As far as ordering a redraw for Resident 58, perhaps she did and it fell off. The 4/13/24, 5:30 p.m. nurse's note read, "QMA [Qualified Medication Aide] called this writer to res [resident's] room. Res was laying in bed lethargic but responded some with slurred speech. BP 160/74 P 68 T 97.9 02 74% RA R 14 Shallow deep breathing. Res was reaching in the air for things that wasn't there. Unable to answer questions fully. As VS [vital signs] were taken [name of PO-power of attorney] POA walked in and ask for res to be sent to ER. Called 911. EMT [Emergency Medical Technicians] arrived and took res to Reid [name of hospital.] Gave paper work to daughter to take to [name of hospital.] DON notified and [name of medical provider] was contacted and notified of transfer to hospital. Res daughter took res glasses to hospital. [Name of hospital]called and gave report to [name of ER staff] in the ER."			

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	The 4/17/24 hospital discharge summary indicated her principal problem was a UTI (urinary tract infection) with an active problem of sepsis due to UTI. It read, "...was admitted from ECF [extended care facility] with increased confusion. She was diagnosed with acute metabolic encephalopathy thought to be secondary to Enterococcus faecalis UTI. She improved with antibiotics. Given microbiology results and risk of interaction between Zyvox and Sinemet she will be discharged on 1 additional dose of IV [intravenous] vancomycin....Patient also had urinary retention which certainly contributed to her agitation and encephalopathy. She is therefore discharged with a Foley catheter in place." The START taking these medications section of the discharge summary indicated to take vancomycin 1.25 gram/250 mL injection into the vein 1 time for 1 dose on 4/19/24. The Urinary Retention section of the 4/17/24 hospital After Visit Summary read, "Urinary retention means you are having trouble urinating. In some cases you may not be able to pass any urine at all. This condition occurs even though your bladder is full. Causes - For girls and women, the most common cause of urinary retention is a bladder infection...Treatment - This condition is treated by putting a tube (catheter) into the bladder to drain the urine. This gives relief right away. The catheter may need to stay in place for a few days....Home Care - If you were given antibiotics to treat a bladder infection, take them until they are used up. Or take them until your healthcare provider tells you to stop. It's important to finish the antibiotics even if you feel better. This is to make sure your infection has cleared. If a catheter was left in place, it's important to keep bacteria from getting into the			

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	collection bag. Don't disconnect the catheter from the collection bag. Use a leg band to secure the drainage tube, so it does not pull on the catheter. Drain the collection bag when it becomes full using the drain spout at the bottom of the bag. Don't pull on or try to take out your catheter. This will harm your urethra. The catheter must be removed by a healthcare provider. Follow-up care - ...If a catheter was left in place, it can often be removed in 3 to 7 days. Some conditions require that thee catheter stays in longer. Your provider will tell you when to come back to have the catheter removed." The 4/17/24, 4:21 p.m. nurse's note indicated Resident 58 returned from the hospital. The April, 2024 facility physician's orders included the order for the one dose of vancomycin to be given on 4/19/24, but did not include any orders regarding her catheter until 4/25/24. They were to apply leg bag for Foley catheter twice a day, starting 4/25/24; to change urinary catheter and drainage bag as needed for occlusion/dislodgement starting 4/25/24; and to provide urinary catheter care every shift, starting 4/25/24. The April, 2024 MAR (medication administration record) indicated Resident 58 did not receive the one dose of vancomycin on 4/19/24. They indicated the orders regarding her catheter did not begin being provided until 4/25/24. An interview was conducted with the DON (Director of Nursing) on 5/14/24 at 12:25 p.m. and 5/14/24 at 1:54 p.m. She indicated Resident 58 did not receive the dose of vancomycin on 4/19/24, as ordered. They caught the error the following week and the nursing staff involved were disciplined.			

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	They were providing catheter care as a standard of practice after her return from the hospital on 4/17/24 through 4/25/24, but did not have orders, documentation of the care, or any other verification to verify that. An interview was conducted with CNA 12 on 5/14/24 at 1:52 p.m. She indicated she worked with Resident 58 often. Since her hospitalization, she had been declining. She wasn't eating as well anymore and was sleeping more often. An interview was conducted with CNA 13 on 5/14/24 at 1:54 p.m. She indicated she worked Resident 58 and she was declining and very tired. The Urinary Catheter Care policy was provided by the DON on 5/14/24 at 2:45 p.m. It read, "The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given. 2. The name and title of the individual giving the catheter care. 3. All assessment data obtained when giving catheter care." 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record	F 0689	**F689Free of Accident**	06/11/2024

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	review, the facility failed to ensure a transfer with utilization of a gait belt and the utilization of a Hoyer (mechanical lift) lift for 2 of 2 randomly observed residents (Resident 36 and Resident 71) and ensure fall interventions were in place for 2 of 7 residents reviewed for accidents (Resident 36 and Resident 62). Findings include: 1. The clinical record for Resident 62 was reviewed on 5/8/24 at 12:20 p.m. His diagnoses included, but were not limited to, dementia. An interview was conducted with Family Member 21 on 5/8/24 at 2:24 p.m. He indicated Resident 62 fell about a month ago and fractured his pelvis. He was in his room around 2:00 p.m. and tried to get up and walk. The staff had told him many times to use his walker or wheel chair. The 4/18/24 post fall assessment indicated Resident 62 had an unwitnessed fall on 4/18/24 at 2:00 p.m. He was found in a supine position, outside of the bathroom door. Prior to the fall he was sitting in his wheel chair. The 4/18/24, 2:29 p.m. nurse's note read, "Resident found on floor unable to make sense of what happened, c/o [complains of] right hip pain, MD notified, new order for right hip x ray, family aware." The 4/18/24, 6:31 p.m. nurse's note read, "Results from X-ray reveal pelvic fracture with mild displacement, oncoming nurse notified M.D. of results, Order to sent resident out to ER [emergency room] obtained." The 4/19/24, 2:29 a.m. nurse's note read, "Resident		**Hazards/Supervision/Devices CFR(s):483.25(d)(1)(2)** **I. Education was provided to the CNA 4 and 5 regarding using a gait belt during transfers, providing diversional activities, and setting up diversional activities for resident 36. The neon tape was also replaced to the call light for resident 36. Education was provided to the CNA 4 and 5 regarding appropriate repositioning technique for resident 71 including using the lift to assist with repositioning. Resident 62's anti-rollback device was repaired during the survey.** **II. Residents requiring transfer assistance and have fall prevention interventions in place have the potential to be affected by the alleged deficient practice. These residents have been reviewed for transfer needs and fall interventions. Care plans have been reviewed and updated as needed.** **III. Education was provided to nursing staff related to Gait belt use, hoyer lifts for repositioning and following the plan of care for fall interventions. Education was also provided for reporting equipment that is missing or**	

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	returned to facility via [name of hospital] transport. VSS [Vital Signs Stable.] Resident diagnosed with Closed displaced fracture of right acetabulum, and pelvis. Acute Cystitis without hematuria. Resident c/o pain in legs and pelvis. prn [as needed] pain medication given. Referral placed with [name of orthopedic provider], they will call facility with appointment time. Resident must remain weight bearing and can sit as tolerated. N.O. [New order] for cephalexin 500mg QID [4 times daily] x [times] 7 days and Norco 5-325mg q [every] 6h [hours] prn pain x 5 days. Resident is resting in bed with call light in reach and no other needs at this time." The 4/19/24, 10:28 a.m. IDT (Interdisciplinary Team) note, recorded as a late entry on 4/24/24 at 10:33 p.m., read, "IDT Post Fall Assessment Fall on 04/18/2024: Resident was observed on floor in room. Resident stated he was trying to "take a leak" prior to fall. Resident was not incontinent at time of fall. Staff last saw resident in his room. Vital signs and neuro checks were initiated. Injuries noted at time of fall was c/o [complaints of] pain to Rt [right] hip, nurse notified provider and NP [nurse practitioner] gave order to obtain a stat [immediately] X-ray. Root cause of fall is that resident was attempting to independently ambulate/transfer. Resident is cognitively impaired with poor safety awareness. Resident is also noted to be impulsive and resistant to the use of the call light. Immediate intervention was to bring to a supervised area and notify provider of pain. Intervention initiated by IDT is for resident to have individualized activities in the afternoon. Care plan updated." Observations of Resident 62 sitting in his wheel chair were made on the following dates and times: 5/8/24 at 12:21 p.m. alone in his room, 5/10/24 at		**not functioning properly. Education will be provided upon hire and annually.** **IV. The DON/Designee will observe resident transfers and repositioning to ensure appropriate technique and equipment is being used, and fall interventions are in place. Audits will occur daily (including Saturdays and Sundays) on various shifts for 5 residents for 4 weeks then, monthly thereafter totaling 12 months of monitoring. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **COMPLIANCE DATE: 6/11/2024**	

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	1:01 p.m. at a dining room table, 5/13/24 at 10:39 a.m. in his room with family, 5/13/24 at 12:33 p.m. at a dining room table, and 5/13/24 at 2:00 p.m. still at a dining room table. There was an antirollback device (device used to help prevent falls that attaches to the back of a wheel chair and grabs the tires when the user stands, preventing the chair from rolling backward) attached to the right side of his wheel chair, but it was missing the left side of the device. An interview was conducted with UM (Unit Manager) 17 on 5/13/24 at 2:05 p.m. at the nurse's desk while Resident 62 was sitting in his wheel chair at a dining room table. Resident 62 was easily visible from the nurse's station. UM 17 observed Resident 62's missing left antirollback and indicated she believed he was supposed have one on the left side, because she'd never known a resident to have one side and not the other. She called the therapy department at this time to let them know about the missing left antirollback. After getting off the phone, she indicated they instructed her to contact the Maintenance Supervisor. UM 17 indicated she didn't work on the unit enough to know whether Resident 62 had the left antirollback device attached to his wheel chair when he fell on 4/18/24. To her knowledge, "he's had that wheel chair since he's been back here," for months. An interview was conducted with RN (Registered Nurse) 18 on 5/13/24 at 2:05 p.m. She indicated Resident 62 had the ability to walk on 4/18/24 when he fell. He used his wheel chair to come to the dining room for meals and used his walker in his room. An observation and interview was conducted with the MS (Maintenance Supervisor) on 5/13/24			

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	at 2:13 p.m. while he was working on Resident 62's wheel chair in the hallway in front of the nurses desk. The MS added the left side of the antirollback device and repositioned the right side of the antirollback device. He indicated the right antirollback was not in a position to prevent rollback, and no one informed him prior to today that the left antirollback was missing. An interview was conducted with the DON (Director of Nursing) on 5/13/24 at 2:33 p.m. She indicated she was unaware if the left antirollback was attached to Resident 62's wheel chair when he fell on 4/18/24. They may not have paid much attention to the antirollback device, since it wasn't a fall intervention listed on his care plan. She wasn't sure if that was the same wheel chair he was in when he fell on 4/18/24 or not. 2. An observation was conducted of Resident 36 on 5/8/24 at 2:06 p.m. She was sitting on the leg rest to her recliner with her feet touching the floor. Certified Nursing Assistant (CNA) 4 and CNA 5 entered the room and put one of each of their arms underneath Resident 36's arms to lift her up and pivot her into her wheelchair. There was no utilization of a gait belt during the pivot transfer. A gait belt was located on top of Resident 36's walker in her room during the observation. A soft touch call light was located on the bedside table to the right side of the recliner. The call light was placed towards the back of the bedside table to where Resident 36 would have to reach backwards to reach the call light. An observation of Resident 36, conducted on 5/8/24 at 2:20 p.m., of her sitting up in her wheelchair at the nurses' station. There was no television or activities being provided. There was a bowling activity being conducted in the Taste of Town room of the facility.			

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	An observation of Resident 36's room, conducted on 5/8/24 at 2:54 p.m., of her call light that did not contain no neon tape around it by her bed. An observation conducted of Resident 36, on 5/8/24 at 3:28 p.m., up in her wheelchair at the nurses' station. There was no television or activities being provided. An observation conducted of Resident 36, on 5/9/24 at 10:11 a.m., up in her wheelchair at the nurses' station. There was no television or activities being provided. An observation conducted of Resident 36, on 5/9/24 at 10:54 a.m., up in her wheelchair at the nurses' station. There was a box of markers and coloring pages that were located on top of the box of markers but not set up for the resident to utilize. An observation conducted of Resident 36, on 5/10/24 at 10:45 a.m., up in her wheelchair at the nurses' station. There was no television or activities being provided. She was leaning to the left and a staff member placed a pillow underneath her left arm. The clinical record for Resident 36 was reviewed on 5/10/24 at 11:46 a.m. The diagnoses included, but were not limited to, Parkinson's disease, repeated falls, malnutrition, and cerebral infarction. A Quarterly Minimum Data Set (MDS) assessment, dated 3/28/24, indicated severe cognitive impairment, the utilization of a walker and wheelchair, substantial/maximal assistance with toileting, bathing, upper and lower body dressing, personal hygiene, sit to stand, and chair			

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	to bed/bed to chair transfer. A fall care plan, updated 4/10/24, indicated Resident 36 was at risk for falling and fall related injuries. The approaches included, but were not limited to, offered diversional activities when up in high traffic areas such as snacks, people watching, puzzles, and at times coloring, offered assistance with transferring to bed or recliner, after meals and toileting, and brightly colored tape to call lights. 3. An observation was conducted of Resident 71 on 5/8/24 at 1:59 p.m. She was slouched down in her wheelchair to where her legs were over the foot pedals and her buttocks was towards the front of her wheelchair cushion. Resident 71 had a lift pad underneath her. CNA 4 and CNA 5 entered the room and put one of each of their arm's underneath both of Resident 71's arms and their other arm towards the back of Resident 71 grabbing onto the back of her pants. CNA 4 and CNA 5 hoisted Resident 71 while underneath her arms and grabbing onto the back of her pants to move her backwards and repositioned in her wheelchair. CNA 5 indicated, at the time of the observation, that she was new to the facility and still undergoing orientation. The clinical record for Resident 71 was reviewed on 5/10/24 at 12:00 p.m. The diagnoses included, but were not limited to, encephalopathy, cerebral infarction, hemiplegia and hemiparesis. An Annual MDS assessment, dated 4/25/24, indicated severe cognitive impairment, dependent for chair to bed/bed to chair transfer, and utilized a wheelchair. A care plan for activities of daily living (ADLs),			

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	updated 3/21/24, indicated Resident 71 was unable to perform ADLs independently. Resident 71 required extensive/maximal assistance for bed mobility, transfers per Hoyer (mechanical) lift and 2 staff members. An interview conducted with the Director of Nursing (DON), on 5/14/24 at 4:24 p.m., indicated the expectations are to follow the appropriate practices for the fall policy and utilization of a gait belt during transfers. A policy titled "Fall Prevention Policy and Procedure", dated May 2016, was provided by the DON on 5/13/24 at 1:10 p.m. The policy indicated the following, "...CARE PLANNING...Fall risk care plans will be kept current by the IDT [interdisciplinary team] and other associates within each community. Individualized interventions on the fall care plan will be duplicated onto care sheets to ensure care plan strategies are integrated into the health system...." The Indiana State Department of Health Nurse Aide Curriculum, revised November 19, 2015, indicated the following, "...PROCEDURE #24: USING A GAIT BELT TO ASSIST WITH AMBULATION...3. Place belt around resident's waist with the buckle in front and adjust to a snug fit ensuring that you can get your hands under the belt...4. Assist the resident to stand on count of three...6. Stand to side and slightly behind resident while continuing to hold onto belt...PROCEDURE #26: TRANSFER TO WHEELCHAIR...2. Place wheelchair on resident's unaffected side...4. Stand in front of resident and apply gait belt around the resident's abdomen...." 3.1-45(a)(1) 3.1-45(a)(2)			

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F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but			

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	are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on interview and record review, the facility failed to ensure pharmacy recommendations were followed-up with timely for 1 of 5 residents reviewed for unnecessary medications. (Resident 22) Findings include: The clinical record for Resident 22 was reviewed on 5/13/24 at 2:17 p.m. The diagnoses included, but were not limited to, bradycardia, nasal congestion, and depressive episodes. A physician order, dated 7/13/23, was noted for Zoloft (antidepressant medication) 50 milligrams daily. A physician order, dated 2/14/24, was noted for Flonase nasal spray; 1 puff in each nostril daily as needed. The order was discontinued on 5/12/24. A pharmacy review, dated 11/16/23, indicated a gradual dose reduction (GDR) request for Resident 22's Zoloft. It was marked as "agree" for the Zoloft to be decreased from 50 milligrams to 25 milligrams. This recommendation was not implemented due to Resident 22 still receiving Zoloft 50 milligrams daily upon record review. A pharmacy review, dated 3/4/24, indicated the Flonase nasal spray to be scheduled for daily use. It was marked as "agree" to schedule the Flonase	F 0756	**F756 Drug Regimen Review, Report Irregular, Act on CFR(s) 473.45©(1)(2)(4)(5)** **I. Resident 22 orders for Zoloft or Flonase Nasal Spray have been discontinued.** **II. All residents have the potential to be affected by the alleged deficient practice. Pharmacy recommendations for the last 30 days have been reviewed to determine all were correctly followed up timely.** **III. Education was provided to nursing staff regarding following pharmacy recommendations timely. The systematic change is the DON/Designee will audit the final report monthly to determine all recommendations were followed up timely.** **IV. The DON/Designee will review through record review the pharmacy report monthly to determine the recommendations were completed and orders processed. This audit will be completed monthly totaling 12**	06/11/2024

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	nasal spray to daily; 1 spray in each nostril. This recommendation was not implemented due to Resident 22 still having a physician order for Flonase nasal spray as needed upon record review. A pharmacy review, dated 4/1/24, indicated the Flonase nasal spray to be discontinued. It was marked as "agree" to discontinue to Flonase. This recommendation was not implemented due to Resident 22 still having a physician order for Flonase nasal spray upon record review. An interview conducted with the Director of Nursing (DON), on 5/14/24 at 4:24 p.m., indicated the pharmacy recommendations were usually followed up with by the DON or the Assistant Director of Nursing (ADON). The process was not being implemented and it was in the process of being changed. A policy titled "Medication Regimen Review", updated 3/09, was provided by the DON on 5/14/24 at 9:20 a.m. The policy indicated the following, "...report in writing any potential irregularities and/or comments to the Director of Nursing Services...The recommendations MUST be addressed and appropriate action taken in a reasonable time frame...." 3.1-25(i)		**months of monitoring. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **COMPLIANCE DATE: 6/11/2024**	
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			

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	comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be			

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	the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained during incontinence care (Resident 3), ensure personal protective equipment (PPE) was donned prior to incontinence care for a resident on enhanced barrier precautions (EBP) (Resident 3), and ensure hand hygiene in between residents during medication administration (Resident 68). Findings include: 1. An observation conducted of incontinence care	F 0880	**F880 Infection Prevention and Control CFR(s):483.80(a)(1)(2)(4)(e)(f)** **I. Resident has not had any signs or symptoms of infection since the annual survey. She is receiving appropriate incontinence care while staff are using enhanced barrier precautions. The CNA 3 and QMA 2 received education during the survey regarding peri care and PPE use. QMA 2**	06/11/2024

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	for Resident 3 was conducted on 5/10/24 at 2:00 p.m. with Qualified Medication Aide (QMA) 2 and Certified Nursing Assistant (CNA) 3. CNA 3 proceeded to remove Resident 3's incontinence brief due to soilage. CNA 3 performed perineal care by utilizing disposable wipes. CNA 3 proceeded to wipe from front to back of the perineum but utilized the same soiled wipe to wipe Resident 3 twice. CNA 3 placed the soiled wipes within the soiled brief and discarded such. CNA 3 took a tube a cream and applied the cream to Resident 3's coccyx area with the same gloves that were soiled from performing incontinence care. Both CNA 3 and QMA 2 did not don PPE prior to conducting incontinence care for Resident 3. The clinical record for Resident 3 was reviewed on 5/13/24 at 10:10 a.m. The diagnoses included, but were not limited to, pressure ulcer of sacral region and diabetes mellitus. A care plan, dated 5/8/24, indicated Resident 3 requires enhanced barrier precautions related to her wound. The approach indicated to apply gown and gloves for high-contact care activities such as toileting needs, providing hygiene, and changing briefs/assisting with toileting needs. 2. An observation was conducted of medication administration, on 5/9/24 at 8:30 a.m., with QMA 2. She proceeded to prepare medications for Resident 45 and administer such medications. QMA 2 returned to the medication cart and started to prepare medications for Resident 68 without performing hand hygiene. There was a bottle containing hand sanitizer on the medication cart. After donning gloves to administer eye drops to Resident 68, QMA 2 doffed her gloves and performed hand hygiene. An interview conducted with QMA 2 during the observation,		**was educated regarding hand hygiene during medication pass during the survey.** **II. Residents that receive peri care per staff, have enhanced barrier precautions and receive medications from staff have the potential to be affected by the alleged deficient practice and have remained free of signs and symptoms of infection,** **III. Education was provided to all nursing staff related to hand hygiene, peri care and enhanced barrier precautions. The systemic change includes education upon hire and annually related to hand hygiene, peri care and enhanced barrier precautions.** **IV. The DON/Designee will audit through direct observation peri care during resident incontinence care for correct infection control technique and enhanced barrier precautions, if ordered, to ensure proper PPE is utilized. The DON/Designee will also audit via direct observation medication pass for hand hygiene during medication pass. This auditing will occur daily (including Saturdays and Sundays) on various shifts for 5 residents for 4 weeks then, monthly**	

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	and she commented "that makes sense" when asked about the hand hygiene not being performed in between residents with medication administration. An interview conducted with the Director of Nursing (DON), on 5/14/24 at 4:24 p.m., indicated they reflect the policy regarding incontinence care, hand hygiene, and donning and doffing of PPE related to residents on enhanced barrier precautions. A policy titled "Hand Washing/Hand Hygiene Policy", printed on March 24, 2016, was provided by the DON on 5/13/24 at 11:51 a.m. The policy indicated to perform hand hygiene before and after direct resident contact, before and after entering isolation precaution settings, before and after assisting a resident with personal care, and after contact with a resident's mucous membranes and body fluids or excretions, and after handling soiled or used linens, dressings, bedpans, catheters and urinals. A document titled "Bed Bath/Perineal Care", undated, was provided by the DON on 5/13/24 at 11:51 a.m. The document indicated the following, "...Perineal care...For Females...Wash between and outside labia in downward strokes, alternating from side to side and moving outward on thighs. Use different part of washcloth for each stroke...." A policy titled "Enhanced Barrier Precautions", revised 4/1/24, was provided by the DON on 5/13/24 at 11:51 a.m. The policy indicated the following, "...EBP is used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs		**thereafter totaling 12 months of monitoring.** **Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **COMPLIANCE DATE: June 11, 2024**	

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	[Multidrug-resistant Organisms] to staff hands and clothing...." 3.1-18(b)(2) 3.1-18(l)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures			

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	to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on interview and record review, the facility failed to ensure pneumococcal immunizations were offered and/or administered for 2 of 5 residents reviewed for immunizations. (Resident 36 and Resident 11) Findings include: 1. The clinical record for Resident 36 was reviewed on 5/14/24 at 10:15 a.m. The diagnoses included, but were not limited to, Parkinson's disease, cerebral infarction, and malnutrition. An immunization record, dated 12/1/21, was provided by the Assistant Director of Nursing	F 0883	**F883 Influenza and Pneumococcal immunizations CFR(s): 483.80(d)(1)(2)** **I. Residents 36 and 11 were offered the pneumococcal vaccine. The vaccines have been ordered and will be administered upon arrival from the pharmacy.** **II. All residents have the potential to be affected by the alleged deficient practice and have been offered the pneumococcal vaccine.**	06/11/2024

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	(ADON) on 5/14/24 at 4:15 p.m. The document indicated the following immunizations administered: Pneumovax-23 (PPSV23) administered on 11/10/1997, & Prevnar-13 (PCV13) administered on 7/11/2017. An immunization consent form, dated 9/29/22, indicated consent was given for the influenza vaccine but not to the pneumococcal vaccine. Under the refusal column there was no indication of refusal for the pneumococcal vaccine. A Quarterly Minimum Data Set (MDS) assessment, dated 3/28/24, indicated the pneumococcal vaccine was not up to date due to "not offered". 2. The clinical record for Resident 11 was reviewed on 5/14/24 at 10:30 a.m. The diagnoses included, but were not limited to, Parkinson's disease, diabetes mellitus, edema, and weakness. Resident 11 was admitted to the facility on 7/22/23. An immunization consent form, undated, was provided by the ADON on 5/14/24 at 4:15 p.m. The document indicated consent was given for the pneumococcal vaccine. There was no indication in Resident 11's clinical record that a pneumococcal vaccine was administered. A Quarterly MDS, dated 4/4/24, indicated the pneumococcal vaccine was not given due to it was offered and declined. An interview conducted with the Director of Nursing (DON), on 5/14/24 at 4:24 p.m., indicated		**Vaccines have been ordered for all residents that consented and they will be administered upon arrival from the pharmacy.** **III. Education was provided to nursing staff related to the pneumococcal vaccine policy. The systemic change includes the DON/Designee will audit all new admissions for consent and will ensure administration of the vaccine if consent is given or the vaccine is due upon admission.** **IV. The DON/Designee will review new admissions to ensure the pneumococcal vaccine is offered and/or administered. This will occur 5 days per week for 4 weeks then monthly for 11 months to total 12 months of monitoring. Results of audits will be reported to the QA Committee monthly to assist with additional recommendations if necessary.** **COMPLIANCE DATE: June 11, 2024**	

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	the Infection Preventionist is responsible for the immunization consents and follow-up regarding to the administration of immunizations. A policy titled "Pneumonia Vaccination Policy", dated 11/8/16, was provided by the DON on 5/14/24 at 2:45 p.m. The policy indicated the following, "...both pneumococcal conjugate vaccine (PCV13, Prevnar 13, Pfizer) and pneumococcal polysaccharide vaccine (PPSV23, Pneumovax, Merck) should be administered routinely in a series to all adults age 65 years and older...In addition to adults age 65 years and older, adults age 19 through 64 years who have the conditions specified below and who have not previously received PCV13 should receive a PCV13 dose during their next vaccination opportunity...PPSV23 is recommended for all people who meet any of the criteria below...1. All adults age 65 years and older...." 3.1-13(a)			
F 9999 Bldg. 00	Based on interview and record review the facility failed to ensure that three hours of yearly dementia care training were completed for 1 of 10 employees (SSD 14), six hours of dementia care training were completed in the first six months of hire for 2 of 10 employees (Dietary Aide 20 and CNA 6), and six hours of dementia care training were completed prior to working on a specialized dementia care unit for 1 of 10 employees reviewed for dementia care training (CNA 7). Findings include:	F 9999	**F9999** **I. The SSD, Dietary aide 20, C NA 6 and 7 have received the required dementia training for 2024.** **II. All residents have the potential to be affected by the alleged deficient practice. Staff have been reviewed for education needs regarding dementia training. Staff without required dementia**	06/11/2024

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	Review of the employee records on 5/14/2024 at 9:50 a.m., indicated SSD 14 (Social Services Director), hired on 10/6/2020, had not completed any dementia training for the 2023 year. Dietary Aide 20, hired on 3/30/2023, had not received any dementia training since hire. CNA 6, hired on 8/1/2023, had not received any dementia training since hire. CNA 7, hired on 12/12/2023, had only received four hours of dementia training since hire. An interview with the Director of Nursing (DON), conducted on 5/14/2024 at 2:00 p.m., indicated that CNA 7 had worked on the locked dementia care unit on occasion. An interview with the HRBP (Human Resource Business Partner), conducted on 5/14/2024 at 3:00 p.m., indicated that text messages were put out to all staff twice last year as reminders to make sure that yearly in-services are complete and up to date. Staff supervisors oversaw making sure that staff were up to date on these in-services. HRBP indicated it "just didn't get done" when asked why these were not completed. The facility policy provided on 5/14/2024 at 2:45 p.m., by DON (Director of nursing), indicated " ...inservice education is intended to provide associates with information concerning their positions, methods, and procedures to follow in implementing assigned duties, and up-to-date information that will assist associates in providing high quality healthcare. This training is provided in compliance with all relevant State and Federal regulations. Associates are required to participate in all required assignments..." [sic] 3.1-14(u)		**training will receive the training.** **III. Education has been provided to all staff regarding dementia training requirements and completing Relias. The systemic change includes the HR Director will review Relias monthly to ensure staff have completed their required assignments.** **IV. The HR Director/ Designee will review staff records for completion of dementia training monthly. This audit will be completed monthly totaling 12 months of monitoring.** **Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **COMPLIANCE DATE: 6/11/2024**	

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: May 8, 9, 10, 13, 14, and 15, 2024. Facility number: 000455 Residential Census: 24 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 5-21-2024	R 0000	**This plan of correction is to serve as Arbor Trace's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Arbor Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **Arbor Trace respectfully requests a desk review for these deficiencies.**	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.			

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	(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to revise the individualized service plan (ISP) for Resident R-4 to include interventions of intrusive wandering for 1 of 5 residents for ISP. Findings include: The clinical record for Resident R-3 was reviewed on 5/10/2024 at 1:00 p.m. The medical diagnosis included chronic kidney disease. Resident R-3 was noted to be reliably interviewable. An interview with Resident R-3 on 5/13/2024 at 12:30 p.m. indicated Resident R-4 had entered her room over the weekend uninvited. She stated that she had awoken early in the morning on 5/12/2024 to Resident R-4 standing at the end of her bed and this had scared her. Resident R-3 indicated that Resident R-4 had entered her apartment four to five times uninvited previously. She stated that staff had intervened a few weeks ago when Resident R-4 was found in Resident R-3's	R 0217	**R217 410 IAC 16.2-5-2 (e) (1-5) Evaluation-Deficiency** **I. Resident R4 has a service plan that addresses wandering into other apartments.** **II. All residential residents that have a history of wandering into other resident have the potential to be affected by the alleged deficient practice.** **III. Education has been provided to the Assisted Living Nursing Staff regarding service plans being in placed for residents who wander into other resident apartments. The**	06/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155481	A. BUILDING 00 B. WING	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR TRACE HEALTH & LIVING COMMUNITY	3701 HODGIN RD RICHMOND, IN 47374

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	apartment. An interview with Unit Manager 19 on 5/15/2024 at 11:30 a.m. indicated that on 5/13/2024 it was reported to her that over the weekend Resident R-3 had awoken to Resident R-4 in her apartment early in the morning. It was her understanding that the event had startled Resident R-3. R-4 had previously entered Resident R-3's apartment uninvited about a month ago. This earlier event had caused Resident R-3 to become upset. An intervention of a sign instructing Resident R-4 to not enter other residents' rooms was placed on the inside of Resident R-4's apartment door, but she did not update the service plan to encapsulate this intervention. The clinical record for Resident R-4 was reviewed on 5/15/2024 at 11:14 a.m. The medical diagnosis included insomnia. A progress note, dated 5/12/2024, indicated that Resident R-4 was found in another resident's room. The individualized service plan for Resident R-4 did not encompass the interventions for her uninvited entrance into other resident's room. An interview with the DON on 5/15/2024 at 12:36 p.m., indicated that the facility did not have a specific policy for updating/revising individualized services plans for residents, but they would follow the state regulations.		**systemic change includes reviewing any wandering behavior daily in stand up meeting and verifying the service plan is updated at that time.** **IV. The DON/Designee will audit through record review residents with wandering behavior during morning stand up 5 times weekly for four weeks then monthly to total 12 months of monitoring. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **COMPLIANCE DATE: 6/11/2024**	