STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155807	A. BUILDING 00 B. WING	08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RURAL HEALTH CARE CENTER	1747 N RURAL ST INDIANAPOLIS, IN 46218

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit resulted in an Extended Survey- Substandard Quality of Care-Immediate Jeopardy. Survey dates: August 22, 23, 24, 25, and 26, 2022. Facility number: 000388 Provider number: 155807 AIM number: 100454140 Census bed type: SNF/NF: 40 Total: 40 Census payor type: Medicare: 1 Medicaid: 39 Total: 40 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 2, 2022	F 0000		
F 0584 SS=E 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, 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	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, observation, and record review, the facility failed to provide a clean, sanitary, and homelike environment for 11 of 11 residents reviewed for environment (Residents 20, 37, 17, 26, 5, 6, 10. 28, 40, 7, and 23)	F 0584	The facility does provide a clean, sanitary, and homelike environment. · what corrective action(s) will be accomplished for those	09/23/2022

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	Findings include: On 8/22/22 at 9:41 a.m., Residents 20 and 37's room was observed. The floor trim was pulling away from the wall. There was a gnat flying in the room. During an interview on 8/22/22 at 9:41 a.m., Resident 20 indicated that he did have gnats in his room at times. On 8/22/22 at 9:51 a.m., Residents 17 and 26's room was observed with a crack going down the wall next to the bathroom. The cove base was pulling away from the bottom of the wall. A gnat was flying in the room. During an interview on 8/22/22 at 9:51 a.m., Resident 17 indicated the wall had been that way for "a while". He did have gnats fly in his room and he thought they sprayed for them. On 08/22/22 10:14 a.m., Resident 5 and 6's room was observed. The wall outlet covers are pulling away from wall. The electrical junction box was covered with a wall outlet cover which did not securely fit over the junction box. The marble windowsill had a crack area with jagged edges exposed. There was a piece of wood onto the marble windowsill which had peeling gray paint. The floor of the room had a grayish appearance and the bathroom wall had peeling paint and the wall was scraped into the drywall. During an interview on 8/22/22 at 10:41 a.m., Resident 10 indicated the facility was not clean. The hallways, rooms, and everywhere in the facility were not kept clean. On 8/22/22 at 10:47 a.m., Residents 28 and 40's room was observed. The cove base was peeling		residents found to have been affected by the deficient practice; Resident 20 and 37’s room floor trim was corrected, crumbling drywall fixed, and no longer has gnats regularly flying around the room. Residents 17 and 26 room’s crack in the wall next to the bathroom was fixed, cove base fixed, electrical outlet cover fixed and no longer has gnats regularly flying around the room. Resident 5 and 6 wall outlet covers fixed, electrical junction box covered with the correct wall outlet cover, crack on Marble window seal repaired, board on windowsill painted after old, peeling paint removed. The floor of grayish appearance mopped, bathroom wall painted and drywall fixed. Resident 28 and 40’s room cove base by the bathroom door fixed and cleaned and no longer has gnats regularly flying around the room. Resident 7 and 23’s room painted and nail holes fixed; door sanded where rusted, and new protective panels added to the door. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	

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	back from with wall by the bathroom door. There was debris caked along the walls and gnats flying around the room. On 8/22/22 at 11:07 a.m., Resident 7 and Resident 23's room was observed. The walls of the room were painted blue with rectangles of a different shade of blue present of the walls. There were multiple nail holes present on the walls. The bathroom door had 2 large rectangles of old adhesive. On 8/26/22 at 11:18 a.m., an environmental round was conducted with the HKS (Housekeeping Supervisor) and the MS (Maintenance Supervisor). Residents 20 and 37's room was observed. The corner of the wall by the bathroom was observed to have broken, crumbling drywall. The MS indicated he had fixed the area once, the resident's run into it with their wheelchairs and the dry wall needed repaired. Residents 17 and 26's room was observed to have the cove base pulling away from the drywall at the bottom of the floor. There was drywall dust/ particles present inside the cove base between the walls. The electrical outlet cover was pulling out of the wall and not secure. Resident 5 and 6's room was observed. The electrical outlet did not securely fit, and the junction box was covered with a standard outlet cover which did not fit securely. The board on the windowsill continued to have peeling paint. During an interview, the MS indicated the outlet covers should fit securely and the wood board did need painted.		All Residents have the risk of being affected by this alleged deficient practice. The acting Maintenance Director completed an audit on 9/16/22 of all Resident rooms and bathrooms to identify any other concerns and to ensure that any identified areas have been addressed. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The acting Maintenance Director has been in serviced on 9/14/22 by the Administrator on the homelike environment policy. A painting, bathroom, and Resident room repair audit will be completed by the Maintenance Director/Designee weekly to ensure homelike environment compliance. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Administrator or designee will audit monthly x 6 months, the compliance of weekly painting, bathroom, and resident room repair audits. The Maintenance Director or designee will report findings monthly via QAPI x 6	

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	Resident 7 and Resident 23's room was observed. The HKS indicated that the room had once been the therapy gym and an office. The different colors of blue paint and nail holes were present due to items which used to hang on the walls. The door had old adhesive present due to protective panels which had peeled off. The room needed the nail holes filled and painted. The door could be fixed by hanging new protective panels. There was an area on the bottom of the door frame which was jagged and rusting. The MS indicated it could be sanded and repaired. Residents 28 and 40's room was observed. The cove base was pulling away from the wall and had drywall dust and debris present between the cove base and the concrete wall. The MS indicated that the dry wall was becoming "soft" and crumbling, which is why the cove base was pulling away. It needed repaired. 3.1-19(f)(5)		months. · by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 9/23/2022	
F 0600 SS=J Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-			

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	§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect a resident from potential sexual abuse by not determining her capacity to consent to sexual interactions with another resident and ensure a resident was free of physical abuse for 3 of 4 abuse reviewed for abuse. (Residents 6, 20, and 28) The Immediate Jeopardy started on 8/10/22 at approximately 10:11 a.m., Certified Nursing Assistant (CNA) 1 observed Resident 20's penis exposed, and he was masturbating while touching Resident 28's breast in the hallway. The facility had concluded the interaction was consented, and if Resident 20 and Resident 28 continued to want to engage in sexual activities; it would be permitted in a private setting. The facility was unable to provide evidence that it had been determined Resident 28 had the mental capacity to consent to sexual interactions. The Administrator (ADM), the Regional Director of Clinical Operations (RDCO), and the Social Services Director (SSD) were notified of the immediate jeopardy on 8/23/22 at 3:00 p.m. The immediate jeopardy was removed, and the deficient practice was corrected by 8/26/22 after the facility implemented a systemic plan that included the following actions: The development and implementation of policies that address the residents' sexual interactions and their capacity to consent to such interactions. Ensure all facility staff are educated on sexual abuse. Findings included: 1. The clinical record for Resident 28 was reviewed on 8/22/22 at 2:00 p.m. The diagnoses	F 0600	The facility does protect residents from potential sexual abuse and physical abuse · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 8/10/22 Resident 20 completed a permanent room change. On 8/10/22 facility notified the Medical Director, guardian, and psych provider of incident. On 8/10/22 Residents completed a medication review. Both residents (20 and 28) have had a determination of mental capacity assessment completed and documented in their medical record by their Medical Director. Decisions were made based on their expertise in the area, including their ability to measure resident knowledge of relevant info such as risk and benefits, understanding, rationale reasoning and resident volunteeredness. The determination will be documented in the resident's medical record. The resident's care plan will be updated to reflect the determination. A list will be maintained at each nurse's station, and updated as changes occur, by the MDS Coordinator, with the determined mental	09/25/2022

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	included, but were not limited to, unspecified psychosis not due to a substance or known physiological condition, anxiety disorder, cognitive communication deficit, intellectual disability, Alzheimer's disease, Paranoid Schizophrenia, and dementia with behavioral disturbances. The resident has a guardian to make health decisions. A Quarterly MDS (Minimum Data Set) assessment, dated 4/24/22, indicated Resident 28 was severely cognitively impaired. An Annual MDS (Minimum Data Set) assessment, dated 7/15/22, indicated Resident 28 was moderately cognitively impaired. A level II Preadmission Screening Determination (PASARR) dated 12/4/14 indicated "...She [Resident 28] is very child like.." A care plan dated 3/15/21 indicated "Residents (28) cognition is impaired aeb [as evidence by] consistently fluctuating BIMS [Brief Interview for Mental Status] scores between 5 and 11. Resident also with impaired decision making abilities and impaired thought processing. DX: [diagnosis] Dementia and Paranoid Schizophrenia...Interventions:...Resident will avoid the risk of safety due to impaired cognition..." A care plan dated 8/21/12 indicated "Resident (28) has a communication problem r/t [related to] slurring and low toned voice. Her ability to understand others and make herself understood fluctuates as does her logical flows of ideas and ability to remain in subject during conversations(s) (sic). At times, resident also chooses not to talk at all. dx: dementia, ID/MI/MR		capacity of each resident as it relates to sexual interaction. There have been no further incidents between residents 6 and 23. Residents were separated at the time of cited incident (5-16-22) and both placed on 1:1 supervision. Residents continue to receive medical and psychiatric follow up regularly. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Facility completed a BIMS audit on all Residents on 8-23-22. Facility completed sexual abuse interviews for all Residents, no other Residents identified concerns of potential abuse. Residents who were not interviewable had a head to toe assessment completed with no negative findings. Residents with a BIMS score of 12 or below will have their primary physician services determine mental capacity regarding the ability to consent to sexual interactions. Findings will be documented in the resident's medical record and reflected on the resident's plan of care. BIMS scores will be completed at admission, re-admission, quarterly and with any significant change in condition. A list will be maintained at each nurse's	

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	[mental illness/Intellectual disability] and Schizophrenia..." A care plan dated 5/10/13 indicated "The Resident voices allegations of mistreatment towards caregivers. This behavior appears to be r/t: difficulty controlling anger and depression, misinterpretation/misperception r/t mental illness, symptoms/problems are manifested by allegations of: verbal abuse, financial abuse and physical abuse. (Accuses staff of hitting, stealing money and shooting her "booty", when she does not get her way.)..." A care plan dated 3/18/16 indicated "Resident (28) often exhibits social inappropriate behaviors such as disrobing in public, not wishing to remain fully clothed, sitting on the floor, licking liquids (juice, pop, etc.) off of the floor, eating food from the floor/trash cans,... DX dementia, ID/MI/MR and Schizophrenia..." A care plan dated 3/23/22 indicated "[Resident 28] has sexually inappropriate behavior r/t dementia. Goal: [Resident 28 will converse w/ [with] others without making any sexual comments through next review...Interventions: Approach the resident in a friendly but direct tone of voice. If inappropriate comments are made tell the resident her comments are inappropriate and are not tolerated. Monitor and record behaviors in behavior log. Praise the resident for demonstrating desired behavior. Refer to psych services as indicated." A psychiatric progress note dated 5/4/22 indicated a mental status examination was conducted on Resident 28. It indicated the resident was moderately impaired to insight and severely impaired with judgement. "Session		station, and updated as changes occur, with the determined mental capacity of each resident as it relates to sexual interaction. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All facility staff educated on the Facility sexual abuse policy on 8-24-22 with a focus on residents mental capacity and sexual interactions. Education provided prior to staff's next scheduled shift to work. Social services director or designee will review the facility behavior logs daily during the facility morning meeting (M-F) and review each incident identified as potential abuse. The MDS coordinator or designee will review all nursing notes daily (M-F) during the facility morning meeting. The designated Facility Manager on Duty will be responsible for reviewing behavior logs and nursing notes on the weekends. All incidents identified as sexual abuse will be reported to ISDH by the Administrator or her assigned designee and the Administrator will ensure an investigation is initiated immediately upon notification and fully completed on each incident. Residents, families and/or POAs will be notified after	

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	included maladaptive communication [high anxiety, repeated questions or disagreement] due to severity of psychiatric impairment disrupting insight and requiring further consultation with facility staff to adequately assess management of psychiatric symptoms and changes to daily functioning (impaired insight,...slowed processing, impaired comprehension)..." The clinical record for Resident 20 was reviewed on 8/22/22 at 10:49 a.m. The diagnoses included, but were not limited to, frontotemperal dementia (it affects behavior and language), cognitive communication deficit, major depressive disorder, anxiety disorder, dementia with behavioral disturbances, bipolar disorder, and Obsessive-Compulsive Disorder. The resident has a guardian to make health decisions. A Quarterly MDS (Minimum Data Set) assessment, dated 5/29/22, indicated Resident 20 was moderately cognitively impaired. A care plan dated 12/6/21 indicated, "The resident (20) has impaired cognitive function/dementia or impaired thought processes r/t forgetfulness, short term memory loss..." A care plan dated 3/23/22 indicated "[Resident 20] has sexually inappropriate behavior r/t Dementia. Goal: The resident will converse w/ [with] others without making any sexual comments through next review of 90 days. Interventions: Approach the resident in a friendly but direct tone of voice. If inappropriate comments are made tell the resident his comments are inappropriate and are not tolerated. Monitor and record behavior in behavior log. Monitor for changes or increases in behavior and report to MD [medical doctor] and/or psych services. Praise the resident for		each incident and educated as needed on the facility sexual abuse policy (i.e. understanding mental capacity as it relates to sexual interaction). All current and any new Residents with a BIMS score of 12 or below will have their primary physician or psychiatric services determine mental capacity regarding the ability to consent to sexual interactions. Findings will be documented in the resident's medical record and reflected on the resident's plan of care. BIMS scores will be completed at admission, re-admission, quarterly and with any significant change in condition. A list will be maintained at each nurse's station, and updated as changes occur, with the determined mental capacity of each resident as it relates to sexual interaction · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Administrator will audit weekly x 6 months to ensure that behavior logs and nurses notes are being reviewed during the Facility morning meetings. The Administrator or Designee will audit each resident's chart and Care Plan, that has a BIMS of 12 or below, monthly, to ensure documentation regarding mental	

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	demonstrating desired behavior. Refer to psych services as indicated." A reportable incident to the Indiana Department of Health was provided by the (ADM) on 8/22/22 at 11:20 a.m. It indicated on 3/14/22 at 9:50 a.m., Resident 28 and Resident 20 had "touched each other inappropriately." The follow up indicated "...residents immediately separated and placed on 1:1 care...[Resident 20] educated to ensure he is being respectful towards his peers. [Resident 28] sent out of facility for a psych stay due to an increased in recent behaviors...Care plans updated..." A psychiatric discharge summary dated 4/5/22 indicated Resident 28's judgement and insight was poor. A psychiatric progress note dated 4/29/22 indicated Resident 20 was currently on 100 milligrams of depo-provera due to inappropriate sexual behavior. Resident 28 and Resident 20's medical records did not indicate the residents' capacity of consenting to sexual interactions were determined at that time. A behavior note for Resident 20 dated 8/10/22 indicated "...A CNA (1) witnessed him touching another resident sexually while he was sexually touching himself. They were slightly standing behind the linen cart and when the CNA walked up to them closely and asked what he was doing, his penis was out and he was masturbating while touching a female resident's [28] breast. He was told that was inappropriate...The administrator was told immediately and was told to put both the residents on 1 to 1's...Another CNA also seen him after he was told to go back to room before he		capacity to determine consent for sexual activity exists. A Designated Facility Manager will make in person observations every shift X 2 weeks, then each shift 2x week for 2 weeks, then each shift weekly x 5 months Findings of all audits and reviews will be reported monthly to the Facility QAPI meeting. · by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. 9/25/22	

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	made it back to his room that his penis was still out of his underwear..." A behavior note for Resident 28 dated 8/10/22 indicated "Resident was found by a CNA letting another resident touch on her in the hall while he was masturbating....They were separated. This resident then went to the front and pulled her dress up in front of someone else but fortunately he did not notice it. The administrator was told immediately..." The 1:1 safety check log dated 8/10/22 for Resident 20 indicated "inappropriate touching another resident." The staff was to conduct safety checks every 15 minutes. The log indicated safety checks were conducted from 10:00 a.m. through 11:00 p.m. There were no other safety checks conducted after 11:00 p.m. on 8/10/22. The 1:1 safety check log dated 8/11/22 for Resident 20 indicated 15 minute safety checks began at 7:00 a.m. through 10:30 a.m. There were no other safety checks conducted on the resident that day. The 1:1 safety check log dated 8/10/22 for Resident 28 indicated 15 minute safety checks were to be conducted regarding inappropriate touching. The log indicated safety checks were conducted from 10:15 a.m. through 11:00 p.m. There were no other safety checks conducted on the resident that day. The 1:1 safety check log dated 8/11/22 for Resident 28 indicated 15 minute safety checks were to be conducted for 24 hours regarding sexual inappropriate behavior. The staff conducted safety checks from 12:00 a.m. through 2:00 p.m. There were no documented safety			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	checks conducted from 2:15 p.m. through 2:45 p.m., and 11:15 p.m. - through 11:45 p.m. The 1:1 safety check log dated 8/12/22 indicated there was no safety checks conducted from 12:45 p.m. through 11:45 p.m. that day. The 1:1 safety check log dated 8/13/22 indicated there was no safety checks conducted from 4:00 p.m. through 11:45 p.m. An IDT [Interdisciplinary team] note documented by ADM dated 8/11/22 indicated "Resident [20] educated by Social Services and Administrator that it is inappropriate to masturbate and do sexual activities in the hallways. Resident stated he understood." An IDT note documented by the ADM dated 8/11/22 indicated "Resident [28] interviewed by Administrator, Social services director and MDS coordinator on the incident regarding a male resident touching her breast. When asked if she consented to this, Resident stated yes! When asked if she liked it, Resident stated yes. Resident educated that it is inappropriate and not allowed to do sexual activities in the hallways. Resident understood." An interview was conducted with the ADM and SSD on 8/23/22 at 12:24 p.m. The SSD indicated the reportable incident on 3/14/22 between Resident's 20 and 28 occurred outside her office in the hallway. She had overheard Qualified Medication Aide (QMA) 2 state, "you can't do that." Resident 28 and Resident 20 were clothed but touching each other in the genitals. The residents were separated and placed on 1 on 1 supervision. Resident 28 was sent out to a psych hospital due to increased behaviors, such as			

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	"yelling and hitting" others leading up to the 3/14/22 incident. Resident 28 was educated. The 2nd incident occurred on 8/10/22 between Resident 20 and Resident 28. CNA 1 had observed Resident 20 had his penis exposed and masturbating while touching Resident 28's breast in the hallway. She indicated both residents comprehend the hallway was not an appropriate place to do the sexual interaction, but she believed they don't care. The staff will educate Resident 20 and 28 to engage in the sexual activities in a private setting not the hallway. An interview was conducted with the ADM in the presence with the SSD on 8/23/22 at 12:24 p.m. The ADM indicated the incident was not reported to Indiana Department of Health, because Resident 28 consented to the sexual interaction. She was interviewed after the incident and verbally stated "yes!" she consented to the sexual touch by Resident 20. The medical provider and psych provider were notified about the incidents, but she did not discuss if the residents have capacity to consent for either resident. The guardians were also notified of the incidents. Resident 20's guardian would like to be notified of sexual interaction occurrences, but did not disapprove. Resident 28's guardian was notified, but messages had to be left on voicemail. There were no discussions with Resident 28's guardian about consenting to the sexual interactions. The IDT met and discussed the occurrences. The IDT had reviewed both residents' BIMs, care plans and had discussions with both residents to decide how to proceed. The sexual touching are so random. Resident 28 liked to be sexually touched by Resident 20, but the hallway was not an appropriate location to do those activities. The ADM had also reached out to corporate for guidance how to address the sexual interaction			

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	between the two residents. The consensual interaction was new to her, and she was unable to determine if appropriate. She wants to protect her residents. The residents are both adults. The ADM believed Resident 28 was able to decide if she would like to participate in sexual interactions, and the resident was able to determine the risks and/or consequences in engaging in sexual activities. The ADM was told by corporate not to report the incident, because both residents consented and liked the sexual interaction. During an interview with the Administrator, the Social Services Director and the RDCO on 8/23/22 at 3:00 p.m., the RDCO indicated she was unable to find a facility policy regarding capacity to consent with sexual interactions. An interview was conducted with Psych Medical Provider 4 on 08/24/22 at 2:52 p.m. She indicated she was made aware of the sexual interactions between Resident 20 and Resident 28 on 3/14/22 and 8/10/22. She had not had any discussions with the staff regarding whether or not the residents had the capacity to consent to sexual activities. Resident 28 was difficult due to her diagnoses. She doesn't answer a lot of questions, and she chooses when she answers questions and/or speaks to you. An interview was conducted with CNA 5 on 08/25/22 at 2:15 p.m. She indicated she had been walking in the hallway and saw a hand behind the linen cart. As she approached, Resident 20's penis was exposed, and he was feeling on himself with one hand and touching Resident 28's clothed breast with his other hand. CNA 5 had stated to Resident 20 at that time, "you can't do that." Resident 28 stated, "he touched my breast."			

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	An interview was conducted with Physician 7 and Physician 7's Registered Nurse (RN) on 8/25/22 at 12:06 p.m. Physician 7 indicated he had recently had a discussion with the staff regarding Resident 28's ability to have sexual interactions, but had not conducted a face to face formal assessment nor did he involve the resident's psych medical provider. He would be conducting an assessment on Resident 20 and 28 that day. During the interview on 8/25/22 at 12:06 p.m., the Physician 7's RN indicated if Resident 28 does not want to do something she could physically hit you. She believed, if sexual interactions were conducted behind closed doors with Resident 28, it would not be safe for her partners. She was unsure how to protect those residents. An abuse policy was provided by the Administrator 8/22/22 at 11:02 a.m. It indicated, "...Policy: Each resident has the right to be free from abuse, neglect, and misappropriation of resident property. All allegations will be reported according to State and Federal Law and investigated. Each nursing home must provide care and services in a person-centered environment in which all individuals are treated as human beings..."Sexual abuse" includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault..." The abuse policy does not address a process of determining a resident's capacity to consent sexual interactions. A Behavior Management policy was provided by the ADM on 8/23/22 at 9:32 a.m. It indicated, "Policy: Residents in long term care facilities may exhibit puzzling and troublesome behaviors. The behaviors may become difficult to handle for staff			

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	and may involve other residents. Sometimes, a resident becomes dangerous to himself or abusive to others and may keep others from enjoying a quiet and peaceful place. The staff should assess the behaviors and document in a quantitative manner, to assist in determining whether the behaviors can addressed in the facility or whether outside assistance may be needed....When a resident experiences a sudden change in behavior or new onset, a medical evaluation should be completed to rule out physical and/or medication related causes for the change in behavior...Handling Difficult Behaviors Internally. Dealing with behaviors is common occurrence in a nursing facility.....Provide 1:1 supervision as needed; encourage the resident to talk to you about what is causing the behavior..." The behavior management policy does not address a process of determining a resident's capacity to consent sexual interactions. 2a. The clinical record for Resident 6 was reviewed on 8/22/22 at 9:45 a.m. The Resident's diagnosis included, but were not limited to, multiple sclerosis and muscle spasms. An Annual MDS (Minimum Data Set) Assessment, completed 5/31/22, indicated she was moderately cognitively impaired. 2 b. The clinical record for Resident 23 was reviewed on 8/23/22 at 10:42 p.m. The Resident's diagnosis included, but were not limited to, schizophrenia and anxiety. An Annual MDS (Minimum Data Set) Assessment, completed 6/14/22, indicated that she was cognitively intact. She displayed verbal behaviors directed toward others 1 to 3 times during the 7-day assessment period. She had			

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	displayed behaviors not directed toward others 1 to 3 times during the assessment period. Her behaviors had worsened since the previous MDS Assessment. During an interview on 8/22/22 at 9:44 a.m., Resident 6 indicated she felt she had been abused by another resident. On 8/23/22 at 9:28 a.m., the Administrator provided a reportable incident between Resident 6 and Resident 23. The reportable incident was dated 5/16/22 at 4:26 p.m. The description of the incident was that Resident 23 had hit Resident 6 on the arm. There were no injuries noted. The immediate action taken was that the residents were immediately separated and placed on 1 on 1 care. Head to toe assessments were completed for each resident and no injuries noted. The family's and physician were notified, and Social Services was monitoring for any psychosocial distress. The follow- up to the incident was dated 5/24/22 and indicated that Resident 23 had hit Resident 16 on the arm. Resident 23 had completed a medication review and there had been no further incidents. The residents suffered no psychosocial distress. The investigation file for the incident was provided on 8/23/22 at 9:44 a.m. It contained a written statement from the Administrator, dated 5/16/22, which indicated she had witnessed Resident 23 hit Resident 6 on the arm. It was not hard contact. During an interview on 8/26/22 at 9:00 a.m., the Administrator indicated she had been the only staff member who had witness the incident. She			

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	immediately separated them and assured both residents were safe. On 8/22/22 at 11:02 a.m., the Administrator provided the Abuse and Neglect Policy, revised 4/1/2017, which read "...Each resident has the right to be free from abuse, neglect, and misappropriation of resident property...Physical abuse includes hitting, slapping, pinching, and kicking... The Immediate Jeopardy that began on 8/10/22 and was removed on 8-26-2022, when the facility implemented a systemic plan that included the following actions: The development and implementation of policies that address the residents' sexual interactions and their capacity to consent to such interactions. Ensure all facility staff are educated on sexual abuse. The non complaince remaind at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm thet is not mmediate jeapordy, becase all emaployes had not been inserviced. 3.1-27(a)(1)			
F 0609 SS=E Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the			

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	events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to timely report an allegation of sexual abuse and submit a follow-up report to an allegation of abuse timely for 4 of 4 residents reviewed for abuse. (Residents 6, 20, 23 and 28) Findings include: 1. The clinical record for Resident 28 was reviewed on 8/22/22 at 2:00 p.m. The diagnoses included, but were not limited to, unspecified psychosis not due to a substance or known physiological condition, anxiety disorder, cognitive communication deficit, intellectual disability, Alzheimer's disease, Paranoid Schizophrenia, and dementia with behavioral disturbances. The resident has a guardian to make health decisions. A Quarterly MDS (Minimum Data Set) assessment, dated 4/24/22, indicated Resident 28	F 0609	The facility does report allegations and follow up of potential sexual abuse in a timely manner. · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident's 6, 20, 23 and 28 now have any allegations of abuse reported in a timely manner per the state regulations as well as the follow up to any reported allegations. · how other residents having the potential to be affected by the same deficient practice will be	09/23/2022

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	was severely cognitively impaired. An Annual MDS (Minimum Data Set) assessment, dated 7/15/22, indicated Resident 28 was moderately cognitively impaired. A care plan dated 3/15/21 indicated "Residents (28) cognition is impaired aeb [as evidence by] consistently fluctuating BIMS [Brief Interview for Mental Status] scores between 5 and 11. Resident also with impaired decision making abilities and impaired thought processing. DX: [diagnosis] Dementia and Paranoid Schizophrenia...Interventions:...Resident will avoid the risk of safety due to impaired cognition..." A care plan dated 8/21/12 indicated "Resident (28) has a communication problem r/t [related to] slurring and low toned voice. Her ability to understand others and make herself understood fluctuates as does her logical flows of ideas and ability to remain in subject during conversations(s) (sic). At times, resident also chooses not to talk at all. dx: dementia, ID/MI/MR [mental illness/Intellectual disability] and Schizophrenia..." A care plan dated 5/10/13 indicated "The Resident voices allegations of mistreatment towards caregivers. This behavior appears to be r/t: difficulty controlling anger and depression, misinterpretation/misperception r/t mental illness, symptoms/problems are manifested by allegations of: verbal abuse, financial abuse and physical abuse. (Accuses staff of hitting, stealing money and shooting her "booty", when she does not get her way.)..." A care plan dated 3/18/16 indicated "Resident (28)		identified and what corrective action(s) will be taken; All resident's have the potential to be affected by this alleged deficient practice · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Administrator was in-serviced by the RDO on 9/22/22 regarding the state requirements for reporting allegations and follow up of potential abuse. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The RDO/Designee will visit or call the facility daily (M-F) to review with the Administrator or Designee, any potential occurrences of abuse that have been identified via the daily review of the facility behavior and nurse's notes and/or were directly reported to the Administrator. The RDO is setup to receive emails verifying reportable information has been sent to the ISDH. The RDO will view the Gateway portal if an allegation has been identified and	

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	often exhibits social inappropriate behaviors such as disrobing in public, not wishing to remain fully clothed, sitting on the floor, licking liquids (juice, pop, etc.) off of the floor, eating food from the floor/trash cans,... DX dementia, ID/MI/MR and Schizophrenia..." A care plan dated 3/23/22 indicated "[Resident 28] has sexually inappropriate behavior r/t dementia. Goal: [Resident 28 will converse w/ [with] others without making any sexual comments through next review...Interventions: Approach the resident in a friendly but direct tone of voice. If inappropriate comments are made tell the resident her comments are inappropriate and are not tolerated. Monitor and record behaviors in behavior log. Praise the resident for demonstrating desired behavior. Refer to psych services as indicated." 2. The clinical record for Resident 20 was reviewed on 8/22/22 at 10:49 a.m. The diagnoses included, but were not limited to, frontotemperal dementia (it affects behavior and language), cognitive communication deficit, major depressive disorder, anxiety disorder, dementia with behavioral disturbances, bipolar disorder, and Obsessive-Compulsive Disorder. The resident has a guardian to make health decisions. A Quarterly MDS (Minimum Data Set) assessment, dated 5/29/22, indicated Resident 20 was moderately cognitively impaired. A care plan dated 12/6/21 indicated, "The resident (20) has impaired cognitive function/dementia or impaired thought processes r/t forgetfulness, short term memory loss..." A care plan dated 3/23/22 indicated "[Resident 20]		verify reporting done timely and follow up completed timely as well. The RDO will correct any non-compliance noted, immediately with the Administrator/Designee x 6 months. The RDO will report findings to the QAPI meeting monthly. · by what date the systemic changes for each deficiency will be completed. 9/23/22	

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	has sexually inappropriate behavior r/t Dementia. Goal: The resident will converse w/ [with] others without making any sexual comments through next review of 90 days. Interventions: Approach the resident in a friendly but direct tone of voice. If inappropriate comments are made tell the resident his comments are inappropriate and are not tolerated. Monitor and record behavior in behavior log. Monitor for changes or increases in behavior and report to MD [medical doctor] and/or psych services. Praise the resident for demonstrating desired behavior. Refer to psych services as indicated." A behavior note for Resident 20 dated 8/10/22 indicated "...A CNA (1) witnessed him touching another resident sexually while he was sexually touching himself. They were slightly standing behind the linen cart and when the CNA walked up to them closely and asked what he was doing, his penis was out and he was masturbating while touching a female resident's (28) breast. He was told that was inappropriate...The administrator was told immediately and was told to put both the residents on 1 to 1's...Another CNA also seen him after he was told to go back to room before he made it back to his room that his penis was still out of his underwear..." A behavior note for Resident 28 dated 8/10/22 indicated "Resident was found by a CNA letting another resident touch on her in the hall while he was masturbating....They were separated. This resident then went to the front and pulled her dress up in front of someone else but fortunately he did not notice it. The administrator was told immediately..." An interview was conducted with the Administrator on 8/22/22 at 11:03 a.m. She			

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	indicated the sexual interaction that occurred on 8/10/22 between Resident 28 and Resident 20 was not reported to the Indiana Department of Health, because both the residents consented to have the sexual interaction. Resident 28 and Resident 20's medical records did not indicate the residents' capacity of consenting to sexual interactions were determined. An abuse policy was provided by the Administrator 8/22/22 at 11:02 a.m. It indicated, "...Policy: Each resident has the right to be free from abuse, neglect, and misappropriation of resident property. All allegations will be reported according to State and Federal Law and investigated. Each nursing home must provide care and services in a person-centered environment in which all individuals are treated as human beings..."Sexual abuse" includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault...Reporting/Response. The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse...are reported immediately to the administrator of the facility. Alleged violations will be reported to the appropriate state agency and to other officials in accordance with Federal and State law..." 3 a. The clinical record for Resident 6 was reviewed on 8/22/22 at 9:45 a.m. The Resident's diagnosis included, but were not limited to, multiple sclerosis and muscle spasms. 3 b. The clinical record for Resident 23 was reviewed on 8/23/22 at 10:42 p.m. The Resident's diagnosis included, but were not limited to, schizophrenia and anxiety. On 8/23/22 at 9:28 a.m., the Administrator provided a reportable incident between Resident 6			

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	and Resident 23. The reportable incident was dated 5/16/22 at 4:26 p.m. The description of the incident was that Resident 23 had hit Resident 6 on the arm. There were no injuries noted. The immediate action taken was that the residents were immediately separated and placed on 1 on 1 care. Head to toe assessments were completed for each resident and no injuries noted. The family's and physician were notified, and Social Services was monitoring for any psychosocial distress. The follow- up to the incident was dated 5/24/22 and indicated that Resident 23 had hit Resident 16 on the arm. Resident 23 had completed a medication review and there had been no further incidents. The residents suffered no psychosocial distress. During an interview on 8/26/22 at 9:00 a.m., the Administrator indicated the follow-up report should have been submitted to the Indiana Department of Health within 5 business days. On 8/22/22 at 11:02 a.m., the Administrator provided the Abuse and Neglect Policy, revised 4/1/2017, which read "...Alleged violations will be reported to the appropriate state agency and to other officials in accordance with Federal and State law..." 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to have evidence of a thorough investigation of an allegation of physical abuse for 1 of 4 residents reviewed for abuse (Resident 23). Findings include: The clinical record for Resident 23 was reviewed on 8/23/22 at 10:42 p.m. The Resident's diagnosis included, but were not limited to, schizophrenia and anxiety. An Annual MDS (Minimum Data Set) Assessment, completed 6/14/22, indicated that she was cognitively intact. The clinical record for Resident 22 was reviewed o 8/23/22 at 10:55 a.m. The Resident's diagnosis included, but was not limited to, anxiety disorder. On 8/23/22 at 9:23 a.m., the Administrator provided an investigation file for a reportable incident which occurred on 5/5/22 at 10:01 p.m. The investigation file contained a Reportable Incident, dated 5/5/22 at 10:01 p.m., which	F 0610	The facility does do a thorough investigation of any allegations of abuse · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 9/14/22 the Social Services Director was educated on the incident investigation policy and procedure. The staff and Resident interviews were completed for incident involving Resident 23. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The Social Services Director completed an audit of last 3 months of reportable incidents to ensure staff and resident interviews were completed, no new findings.	09/23/2022

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	155807	A. BUILDING 00 B. WING	08/26/2022

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	indicated a bruise had been found on the chest and forehead of Resident 23. When asked how the bruises happened, she indicated that Resident 22 had caused them by hitting her. The immediate action taken was the residents were separated and placed on 1 on 1 supervision. Resident 23 was moved to a different room temporarily. A head-to-toe assessment was completed for each resident and social services would be monitoring for psychosocial distress. The investigation file also included a care plan for Resident 23, initiated 3/13/18, which indicated she had a history of making false statements, claims and accusations against staff and peers such as someone burned her, made threats. Copies of the head-to-toe assessments which were completed for each resident on 5/5/22 and the documentation of 1 on 1 supervision which was provided for each resident. The investigation file did not contain any interviews of staff or other residents. On 8/23/22 at 3:20 p.m., the nursing daily staffing schedule for 5/5/22 was provided by the Minimum Data Set Coordinator, which indicated that QMA (Qualified Medication Aide) 2 and QMA 3 had worked on that day on the evening shift. During an interview on 8/23/22 at 12:01 p.m., QMA 2 indicated she vaguely remember the bruise on Resident 23's forehead. She did not remember being asked about the bruises. During an interview on 8/23/22 at 3:38 p.m., QMA 3 indicated she did not remember being asked about any bruises found on Resident 23. She had no knowledge about any bruises on Resident 23's chest.		· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Social Services director or designee will review weekly the reportable incident binder to ensure completion of Resident and staff interviews for all incidents. ·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Administrator or designee will complete a weekly compliance audit to ensure all reported incidents include Resident and staff interviews. The Administrator will report any findings to QAPI monthly x 6 months. · by what date the systemic changes for each deficiency will be completed. 9/23/22	

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	During an interview on 8/26/22 at 9:00 a.m., the Administrator indicated she had interviewed the staff about the bruises found on 5/5/22. None of the staff had knowledge of the bruises or witnessed any abuse. The interviews had been written down; however, she was unable to locate them. On 8/22/22 at 11:02 a.m., the Administrator provided the Abuse and Neglect Policy, revised 4/1/2017, which read ..." The facility will document the findings of the investigation on an investigation form developed by the facility unless a different form is required by state law..." 3.1-28(d)			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and 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			

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	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.			
	Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for a resident with an indwelling urinary catheter for 1 of 14 residents whose care plans were reviewed. (Resident 38) Findings include: The clinical record for Resident 38 was reviewed on 8/22/22 at 10:21 a.m. Resident 38's diagnoses included, but not limited to, major depressive disorder, anxiety disorder, and disorder of the kidney and ureter. An interview with Resident 38 was conducted on 8/22/22 at 10:23 a.m. Resident 38 indicated, he has	F 0656	The facility does develop and implement comprehensive person-centered care plans for residents with indwelling urinary catheters · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 38 care plan was updated by the MDS coordinator to reflect the Residents indwelling urinary catheter. MDS coordinator was educated by the	09/23/2022

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	had an indwelling urinary catheter for over 6 months and wants it to be taken out but his Nephrologist (kidney physician) appointment had not occurred yet. Resident 38's current care plan was reviewed. There was no care plan related to an indwelling urinary catheter. An interview with MDS (Minimum Data Set) coordinator conducted on 8/25/22 at 9:10 a.m. indicated, "he absolutely should have a care plan for his Foley[a brand name for a urinary catheter] catheter. I just overlooked it." A Comprehensive Care Plan policy was received on 8/23/22 at 10:32 a.m. from MDS. The policy indicated, "The comprehensive care plan is based on a thorough assessment that included, but is not limited to, the MDS. 3. 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; d. Reflect the resident's expressed wishes regarding care and treatment goals; e. Reflect treatment goals, timetables and objectives in measurable outcomes; f. Identify the professional services that are responsible for each element of care; g. Aid in preventing or deducing declines in the resident's functional status and/or functional levels; h. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and i. Reflect currently recognized standards of practice for problem areas and conditions."		Administrator on the person-centered care plan policy. -how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The MDS Coordinator completed an audit of all Residents indwelling urinary catheter's included care plans. Audit found no new findings. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; MDS coordinator was educated by the Administrator on the person-centered care plan policy. The MDS coordinator or designee will complete a daily audit Monday-Friday x 6 months, of all new orders, ensuring new orders are care planned. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Administrator or designee will randomly select 5 resident care plans per week and review to	

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	3.1-35(a) 3.1-35(b)		ensure an accurate, person-centered care plan is in place x 2 months and then 1 resident weekly for 4 months. The Administrator will report any findings to QAPI monthly x 6 months. · by what date the systemic changes for each deficiency will be completed 9/23/22	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable			

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	for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure care plan meetings were conducted quarterly and involved the resident/resident representative for 1 of 14 residents whose care plans were reviewed. (Resident 38) Findings include: The clinical record for Resident 38 was reviewed on 8/22/22 at 10:21 a.m. Resident 38's diagnoses included, but not limited to, major depressive disorder, anxiety disorder, and disorder of the kidney and ureter. An interview with Resident 38 conducted on 8/22/22 at 10:20 a.m. indicated, he has not had a care plan meeting since he arrived at the facility. A review of Resident 38's clinical record completed on 8/23/22 at 10:03 a.m. indicated, Resident 38's last care plan meeting occurred on 11/16/21. An interview with SSD (Social Services Director) conducted on 8/23/22 at 10:09 a.m. indicated, she was unable to locate the record of any care plan meetings with Resident 38 other than the 11/16/21 meeting. She indicated, the MDS coordinator usually fills out the care plan meeting form then places it in the chart.	F 0657	The facility does ensure care plan meetings are conducted quarterly and the residents and/or resident representatives are involved. · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 38 care plan meeting was held 8/22/22. MDS coordinator and Social Services Director were educated by the Administrator on the comprehensive care plan meeting policy and procedure. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents are at risk for this alleged deficient practice. The MDS coordinator completed an audit of the last 3 months of Resident care plan meetings held. No new findings were found during the audit.	09/23/2022

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	An interview with MDS coordinator conducted on 8/23/22 at 10:37 a.m. indicated, she was unable to locate the record of a care plan meeting other than the 11/16/21 meeting. She further indicated, some charts had been thinned and some of the paperwork may have been lost. She did not believe Resident 38's chart had been thinned since he had just arrived at the facility in November 2021. A Comprehensive Care Plan policy was received on 8/23/22 by MDS at 10:32 a.m. The policy indicated, "The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. When such refusals are made, appropriate documentation will be entered into the resident's clinical records in accordance with established policies." A Care Planning-Interdisciplinary Team policy was received on 8/23/22 at 10:32 a.m. from MDS indicated, "The resident, the resident's family and or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 4. Every effort will be made to schedule care plan meetings at the best time of day for the resident and family." 3.1-35(e)		· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The MDS coordinator and Social Services Director were educated by the Administrator on the comprehensive care plan meeting policy and procedure. The MDS coordinator or designed will complete a weekly audit of all Residents to ensure that all quarterly, admission, change of conditions care plan meetings were held and Residents and/or resident representatives were invited. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Administrator or designee will complete a weekly audit ensuring all required care plan meetings were held and Resident and/or resident representative invites sent out. Findings will be reported monthly to QAPI x 6 months. · by what date the systemic changes for each deficiency will be completed.	

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F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. Based on interview and record review, the facility failed to ensure the staff had developed a discharge summary and reconciliation of medications for 1 of 1 residents reviewed for	F 0661	The facility does develop a discharge summary and reconciliation of medications for residents discharged.	09/23/2022

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	discharged. (Resident 41) Findings include: The clinical record for Resident 41 was reviewed on 8/26/21 at 12:30 p.m. The diagnosis for Resident 41 included, but was not limited to, chronic kidney disease. A notice of transfer or discharge form dated 6/27/22 indicated Resident 41 had discharged to home. Resident 41's clinical record did not include a discharge summary or reconciliation documentation of his medications. An interview was conducted with the Regional Director of Clinical Operations (RDCO) on 8/26/22 at 10:39 a.m. She indicated she was unable to locate a discharge summary and reconciliation of Resident 41's medications. The discharge policy was provided by the RDCO on 8/26/22 at 11:50 a.m. It indicated "...Policy Statement...1. When the facility anticipates a resident's discharge to a private residence,...a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new environment. 2. The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at that time of the discharge in accordance with established regulations governing release of resident's information and as permitted by the resident. The discharge summary shall include a description of the resident': a. medically defined condition and prior medical history...b. medical status measurement....c. physical and mental		· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 41 previously discharged to home on 6/27/22. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All Residents who reside and discharge from the facility have the potential to be affected by this alleged deficient practice. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nursing staff in serviced and educated on the facility discharge summary and reconciliation of medication policy on 9/19/22. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and MDS coordinator or designee will audit any resident discharge	

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	functional...d. sensory and physical impairments...e. nutritional status and requirements...f. special treatments or procedures...g. mental and psychosocial status...h. discharge potential...I. dental condition...j. activities potential...k. rehabilitation potential...l. cognitive status...m. drug therapy..." 3.1-36(a)		records for completion of discharge summary and reconciliation of medications-on-going x 6 months. MDS coordinator or designee will bring the findings of the audits to QAPI monthly for 6 months. · by what date the systemic changes for each deficiency will be completed. 9/23/22	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility failed to provided assistance with bathing, as scheduled, for 3 of 3 residents reviewed for ADLs (activities of daily living.) (Resident 10, 33, and 38) Findings include: 1. The clinical record for Resident 10 was reviewed on 8/22/22 at 10:00 a.m. The diagnoses included, but were not limited to, paraplegia and Spina Bifida. The 6/9/22 Annual MDS (Minimum Data Set) assessment indicated she had a BIMS (brief	F 0677	The facility does provide residents assistance with bathing as scheduled. · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 10, 33, and 38 showers were completed. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	09/23/2022

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	interview for mental status score) of 15, indicating she was cognitively intact. She required physical help of one person in part of bathing. The 6/23/21 ADL care plan indicated a bathing intervention was to assist her as needed and to offer showers/baths per her preference. An interview was conducted with Resident 10 in her room on 8/22/22 at 10:17 a.m. She indicated she was not getting her showers as scheduled. Her shower days were scheduled twice weekly on Mondays and Thursdays. She was getting one "maybe every 2 weeks," and she was not refusing showers. An interview was conducted with CNA (Certified Nursing Assistant) 8 on 8/23/22 at 11:28 a.m. She indicated they documented showers on shower sheets located in the shower binder at the nurse's station. If a resident refused a shower, they still completed a shower sheet indicating refused and placed it into the binder. An interview was conducted with CNA 9 on 8/23/22 at 11:55 a.m. She indicated they documented showers on shower sheets and placed them into the binder at the nurse's station. Shower sheets were always completed for bathing. The shower binder at the nurse's station was reviewed on 8/23/22 at 11:10 a.m. It included a schedule, updated 5/12/22, that indicated her showers were scheduled for Mondays and Thursdays on day shift. The August, 2022 shower sheets for all residents were included in the binder. There were 3 August, 2022 shower sheets for Resident 10 dated 8/9/22, 8/18/22, and 8/22/22, all indicating a completed shower. The shower		Interim Director of Nursing completed an audit of the last month of showers to ensure all showers and/or refusals were completed and/or documented for all residents · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff educated on 9/19/22 of bathing policy. The MDS coordinator or designee will complete daily shower audits Monday – Friday x 6 months. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Administrator or designee will complete a weekly audit of the shower book x 6 months. Administrator or designee will report any new findings to QAPI x 6 months. · by what date the systemic changes for each deficiency will be completed. 9/23/22	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RURAL HEALTH CARE CENTER	1747 N RURAL ST INDIANAPOLIS, IN 46218

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	sheets had an option to select refused. There were no shower sheet refusals for Resident 10, and there were no shower sheets for Monday 8/1/22, Thursday 8/4/22, Thursday 8/11/22, or Monday 8/15/22. 2. The clinical record for Resident 33 was reviewed on 8/24/22 at 10:28 a.m. Resident 33's diagnoses included, but not limited to, left leg BKA (below knee amputation), paranoid schizophrenia, and chronic obstructive pulmonary disease. Resident 33's Admission MDS (minimum data set) dated 9/30/21 indicated, the importance of choosing between a tub bath, bed bath, or shower was "somewhat important". Resident 33's quarterly MDS dated 7/3/22 indicated, Resident 33 was cognitively intact and required extensive assistance of two persons for transfers; extensive assistance of one person for bed mobility, dressing and personal hygiene; and the physical help of one person in part for bathing activities. An observation of Resident 33 was conducted on 8/22/22 at 9:37 a.m. Resident 33 was lying in his bed and noted to have long fingernails. The underside of his fingernails were packed with a brown substance. He indicated, he had not been receiving his twice weekly baths. Resident 33's care plan dated 10/21/21 indicated, he had an ADL (activities of daily living) self care deficit related to his impaired gait/balance, weakness, paranoid schizophrenia and chronic obstructive pulmonary disease. The interventions included, but not limited to, provide necessary materials/equipment. (soap, shampoo, washcloth, towel, razor, shaving cream, toothpaste,			

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	toothbrush, articles of clothing,etc.) and make sure the materials/equipment are clean and functioning appropriately; required one persons assistance with bathing; and to check nail length and trim and clean on bath day and as necessary. Resident 33's July and August shower sheets were reviewed on 8/23/22 at 10:48 a.m. The shower sheets indicated the following: 7/4/22 - partial bath 7/25/22 - bed bath 8/1/22 - form was left blank 8/23/22 - complete bed bath Resident 33 did not receive a bath at least twice weekly. 3. The clinical record for Resident 38 was reviewed on 8/22/22 at 10:21 a.m. Resident 38's diagnoses included, but not limited to, major depressive disorder, anxiety disorder, disorder of the kidney and ureter, spastic paraplegia (paralysis of the legs and lower body). Resident 38's annual MDS dated 8/1/22, indicated, Resident 38 was cognitively intact, required extensive assistance of two persons for bed mobility and transfers; extensive assistance of one person for personal hygiene; and the physical help of one person in part for bathing activities. It also indicated, the importance of choosing between a tub bath, bed bath, or shower was "very important". Resident 38's care plan dated 11/10/21 indicated, he had an ADL self care performance deficit related to spastic paraplegia, general weakness and decreased mobility. The interventions included, but not limited to, for bathing, the resident was "totally dependent on staff to provide a bath twice weekly and as necessary".			

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	An observation of Resident 38 conducted on 8/22/22 at 10:21 a.m. noted him to have long fingernails. The underside of his fingernails were packed with a brown substance. Resident 38 indicated, at the same time as the observation, he had not been receiving a bath twice weekly and he preferred showers to bed baths. Resident 38's July and August shower sheets were reviewed on 8/23/22 at 10:48 a.m. The shower sheets indicated the following: 7/14/22 - bed bath 7/21/22 - bed bath 7/28/22 - bed bath 8/11/22 - bed bath 8/18/22 - bed bath 8/23/22 - complete bed bath Resident 38 did not receive a bath at least twice weekly. The Shower/Tub Bath policy was provided by the RDCO (Regional Director of Clinical Operations) on 8/26/22 at 11:19 a.m. It read, "The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin....Documentation The following information should be recorded on the resident's ADL record and/or in the resident's medical record: 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath. 3. All assessment data...obtained during the shower/tub bath. 4. How the resident tolerated the shower/tub bath. 5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken.			

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	6. The signature and title of the person recording the data." 3.1-38(a)(3) 3.1-38(b)(2)			
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 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 apply bacitracin, administer medications, and check blood glucose levels as ordered, to 1 of 2 residents reviewed for skin conditions and 4 of 5 residents reviewed for unnecessary medications. (Residents 1, 6, 10, 32, and 39) Findings include: 1. The clinical record for Resident 10 was reviewed on 8/22/22 at 10:00 a.m. The diagnoses included, but were not limited to, paraplegia and Spina Bifida. The 6/9/22 Annual MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status score) of 15, indicating she was cognitively intact. An interview and observation was conducted with Resident 10 in her room on 8/22/22 at 10:17	F 0684	The facility does apply ointments, administer medications and check blood glucose levels as ordered. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 10 now receives treatments and medications as ordered Resident 1 receives treatments and medications as ordered Resident 32 now receives medications as ordered Resident 6 now receives medication and supplements as ordered Resident 39 now receives medication and blood glucose checks as ordered.	09/23/2022

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	a.m. She was sitting in her wheel chair. The bottom half of her left foot was wrapped in a dressing with a date of 8/19/22 written on it. There was a yellowish, brown drainage coming through the tip of the dressing in the great toe area. Resident 10 indicated she bumped into her doorway and her foot started bleeding, approximately 3 weeks ago. Staff was supposed to change the dressing everyday, "but they don't." The 8/3/22 nurse's note read, "Resident hit her l [left] foot on a doorway and scraped her outer great toe. She has a skin tear noted. Called MD and has a order to clean area with wound cleaner, pat dry apply small amt [amount] of bacitracin cover with dry dressing daily until healed. Order has be [sic] put in [name of electronic health record.] Resident has no complaint of pain." The physician's orders indicated to apply Bacitracin Ointment to her left outer great toe one time a day for a skin tear until healed, starting 8/4/22. The August, 2022 TAR (treatment administration record) indicated the Bacitracin was not applied on 8/7/22, 8/8/22, 8/11/22, or 8/22/22. The Skin Management policy was provided by the MDS Coordinator on 8/24/22 at 9:54 a.m. It read, "Treatment of Skin Tears...All skin tears will be assessed, documented, and treated based on physician's orders initiated by the nursing staff....The physician will be notified of the occurrence and the Licensed Nurse will initiate the facility guidelines for skin tears upon attending physician's order. Documentation...Daily treatment is entered in Treatment Record (TAR)." 2. The clinical record for Resident 1 was reviewed		· how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The facility MDS coordinator completed a medication audit on 9/14/22 of all resident's medication administration record to ensure all identified areas have been addressed. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All licensed nurses and QMA's were in serviced on 9/19/22 on the facility medication administration policy. . how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The medication administration record will be reviewed daily Monday-Friday by the MDSC/Designee to ensure daily compliance- non-compliance will be addressed with further education and/or disciplinary action as needed. Daily audit will occur x 1 month, then weekly x 2	

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	on 8/25/22 at 11:00 a.m. The diagnoses included, but were not limited to: chronic kidney disease, vascular dementia, type 2 diabetes, hypertension, seizures, insomnia, anxiety, unspecified psychosis, and hyperlipidemia. The physician's orders indicated to administer one tablet of Divalproex Sodium Tablet Delayed Release 500 MG, three times a day, starting 4/29/22; one 50 mg tablet of trazodone at bedtime for insomnia, starting 4/28/21; two 10 mg tablets of buspirone every 12 hours for anxiety, starting 4/29/21; one 1000 mg tablet of leevetiracetam every 12 hours; 14 units of Lantus 100 unit/ml insulin at bedtime, starting 8/16/22; one 200 mg tablet of Quetiapine at bedtime, starting 4/28/21; one 40 mg tablet of Atorvastatin Calcium at bedtime; one 10 mg tablet of Aricept at bedtime; and to apply Ammonium Lactate Cream 12% to his bilateral feet twice daily, starting 10/20/21. The August, 2022 MAR (medication administration record) indicated the Divalproex tablet was not administered on the following dates and times: 8/2/22 at 6:00 a.m., 8/12/22 at 6:00 a.m. and 2:00 p.m., 8/13/22 at 10:00 p.m., 8/15/22 at 6:00 a.m. and 10:00 p.m., 8/18/22 at 6:00 a.m., and 8/21/22 at 6:00 a.m.; the trazodone was not administered on 8/13/22 or 8/15/22; the buspirone was not administered on 8/13/22 at 10:00 p.m. or 8/15/22 at 10:00 p.m.; the levetiracetam was not administered at 10:00 p.m. on 8/13/22 or 8/15/22; the Lantus was not administered on 8/16/22, 8/17/2, 8/18/22, or 8/19/22; the Quetiapine was not administered on 8/13/22 or 8/15/22; the Atorvastatin was not administered on 8/13/22 or 8/15/22; the Aricept was not administered on 8/13/22 or 8/15/22; and the Ammonium Lactate Cream was not applied to his feet on 8/2/22 at 6:00 a.m., 8/12/22 at 6:00 a.m., 8/15/22 at 6:00 a.m.,		months and then Every other week x 3 months. The MDSC will report findings to the QAPI committee monthly. · by what date the systemic changes for each deficiency will be completed. 9/23/22	

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	8/18/22 at 6:00 a.m., or 8/21/22 at 6:00 a.m.3. The clinical record for Resident 32 was reviewed on 8/25/21 at 12:00 p.m. The diagnosis for Resident 32 included, but was not limited to, type 2 diabetes mellitus. A physician order dated 8/21/21 indicated Resident 32 was to receive 10-40 milligrams (mg) of ezetimibe-simvasatin at bedtime. A physician order dated 7/22/20 indicated Resident 32 was to receive 20 mg of xarelto at bedtime. A physician order dated 10/16/20 indicated the resident was to receive 500 mg of metformin twice a day. A physician order dated 10/5/20 indicated the resident was to receive 6 units of humalog insulin with meals. The August 2022 Medication Administration Record (MAR) indicated the following days, shifts and medications that were not administered as ordered for Resident 32: ezetimibe-simvastatin 10-40 mg - 8/5/22, 8/6/22, 8/7/22, 8/13/22, 8/15/22, 8/18/22, 8/21/22, and 8/22/22, xarelto 20 mg - 8/5/22, 8/6/22, 8/7/22, 8/13/22, 8/15/22, 8/18/22, 8/21/22, and 8/22/22, metformin 500 mg - 8/6/22 - evening shift, 8/7/22 - evening shift, 8/13/22 - evening shift, 8/15/22 - evening shift, 8/18/22 - evening shift, and 8/21/22 - evening shift, humalog 6 units of insulin - 8/3/22 - 12:00 p.m., and			

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	8/18/22 - 4:30 p.m., An interview was conducted with Minimum Data Set (MDS) Coordinator on 8/25/22 at 10:53 a.m. She indicated she was unable to confirm Resident 32 had received the ezetimibe-simvastatin, xarelto, meformin and humalog medications on those missing days. 4. The clinical record for Resident 6 was reviewed on 8/22/22 at 9:45 a.m. The Resident's diagnosis included, but were not limited to, multiple sclerosis and muscle spasms. A physician's order dated 6/17/21. indicated she was to receive Gabapentin 300 mg (milligram) capsule by mouth 2 times daily for muscle spasms. A Physician's order, dated 6/21/21, indicated she was to receive Tecfidera delayed release 240 mg capsule by mouth 2 times daily for her multiple sclerosis. A care plan, initiated 6/21/21, indicated Resident 6 had a diagnosis of MS (multiple sclerosis). The goal was that she would be free of complications related to her MS. The interventions included, but were not limited to, give medications as ordered and monitor for side effects and effectiveness, initiated 6/21/21, and provide pain management as needed, initiated 6/21/21. A physician's order, dated 7/2/21, indicated she was to receive 285 ml(milliliter) of Ensure (nutritional supplement) by mouth 2 times daily for weight loss. An Annual MDS (Minimum Data Set) Assessment, completed 5/31/22, indicated she was moderately cognitively impaired.			

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	During an interview on 8/22/22 at 10:16 a.m., Resident 6 indicated she did not always get her ensure supplement or her medications when she was supposed to. The July and August MAR (Medication Administration Record) were reviewed on 8/25/22 at 2:30 p.m., and indicated her gabapentin 300 mg capsule and Tecfidera delayed release 240 mg capsule, and her 285 ml of Ensure had not been documented as administered on the following days and times: 7/1- morning, 7/2- morning and evening, 7/4- evening, 7/9- evening, 7/10- evening, 7/11- morning, 7/16- evening, 7/22- morning, 7/25- evening, 8/11- evening, 8/13- evening, and 8/15- evening. On 8/25/22 at 3:52 p.m., the Regional Director of Clinical Operations provided the current Medication Administration General Guidelines which read "...Documentation...1. The individual who administers the medications dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medication..."5. The clinical record for Resident 39 was reviewed on 8/22/22 at 1:29 p.m. Resident			

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	39's diagnoses included, but not limited to, type II diabetes mellitus, hemiplegia affecting right side, pulmonary embolism (blood clot in the lungs), and schizophrenia. A physician's order dated 6/17/21 indicated, to give one 2.5 mg Eliquis(an anticoagulant) tablet by mouth every morning and at bedtime related to acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity. A physician's order dated 2/24/22 indicated, to perform blood glucose checks two time a day for diabetes. Resident 39's July and August MARs (medication administration record) were received on 8/23/22 at 12:30 p.m. from MDS (minimum data set) coordinator. On the following dates and times, Resident 39's MAR was left blank for the administration of her Eliquis tablet: 7/1/22 - 9 p.m. dose 7/2/22 - 9 a.m. and 9 p.m. doses 7/4/22 - 9 p.m. dose 7/5/22 - 9 p.m. dose 7/6/22 - 9 p.m. dose 7/7/22 - 9 p.m. dose 7/10/22 - 9 p.m. dose 7/11/22 - 9 p.m. dose 7/12/22 - 9 p.m. dose 7/13/22 - 9 p.m. dose 7/22/22 - 9 a.m. dose 7/23/22 - 9 a.m. dose 7/25/22 - 9 p.m. dose 7/26/22 - 9 p.m. dose 8/5/22 - 9 p.m. dose 8/6/22 - 9 p.m. dose 8/7/22 - 9 p.m. dose 8/8/22 - 9 p.m. dose 8/9/22 - 9 p.m. dose			

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	8/10/22 - 9 p.m. dose 8/11/22 - 9 p.m. dose 8/13/22 - 9 p.m. dose 8/15/22 - 9 p.m. dose 8/18/22 - 9 p.m. dose 8/19/22 - 9 p.m. dose 8/21/22 - 9 p.m. dose 8/22/22 - 9 p.m. dose Resident 39's TAR (treatment administration record) for July and August was received on 8/23/22 at 12:30 p.m. from MDS (minimum data set) coordinator. Neither the MARs or TARs contained information if/when blood glucose checks had been performed and recorded. Resident 39's clinical record under the "vitals tab" indicated, the last blood glucose check was recorded on 2/4/22 at 6:16 a.m. Resident 39's care plan dated 6/23/21 contained a care plan for diabetes mellitus. The interventions included, but not limited to, complete a fasting serum blood sugar as ordered and to perform finger sticks as ordered. An interview with MDS conducted on 8/25/22 at 10:26 a.m. indicated, the facility does not have a permanent DON (Director of Nursing) but, when they did have a DON they would usually look back behind the nurses' charting and ensure both the charting and medication administration was completed. MDS indicated, she cant explain what happened on the days the MAR's were left blank. A Medication Administration General Guidelines policy was received on 8/25/22 at 3:52 p.m. from NC (nurse consultant). The policy indicated, "Medications are administered as prescribed in accordance with good nursing principles and			

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	practices and only by persons legally authorized to do so...The medication administration record (MAR) is always employed during medication administration...15. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR is "flagged". After completing the medication pass, the nurse returns to the missed resident to administer the medication...Documentation 1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medications is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications...6. If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time... the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record. If 3 consecutive doses of a vital medication are withheld, refused, or not available the physician is notified. Nursing document the notification and physician response." 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and			

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	§483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on observation, interview, and record review, the facility failed to follow through on a resident's prescription for eye glasses for 1 of 1 residents reviewed for vision services. (Resident 40) Findings include: The clinical record for Resident 40 was reviewed on 8/22/22 at 10:40 a.m. The diagnoses included, but were not limited to, type 2 diabetes and hypertension. The 7/26/22 Quarterly MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status) score of 15, indicating she was cognitively intact. An observation and interview was conducted with Resident 40 in her room on 8/22/22 at 10:46 a.m. She indicated she had vision issues, needed glasses, and hadn't had any glasses in a long time. She stated, "I can't see." The physician's orders indicated she may be seen by the optometrist as needed, effective 12/12/17. The 2/21/22 optometry note indicated the reason for her visit today was annual exam, decreased vision @ D&N [day and night,] check cataracts, dry eyes, and itchy eye. She presented with the following problems: "blurred vision, check cataracts, itchy eye." It indicated her visual acuity	F 0685	The facility does follow through on resident's prescriptions for eye glasses what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 40 glasses were ordered. The Resident does not have an order for artificial tears. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Social services completed a 3-month audit of eye doctor orders to identify any other identified concerns. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Social services director was in serviced on the facility ancillary services policy and procedure on 9/14/22.	09/23/2022

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	155807	A. BUILDING 00 B. WING	08/26/2022

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	without correction was OD (oculus dexter/right eye): 20/100 and OS (oculus sinister/left eye): 20/100. Her previous glasses were OD: -2.50 and OS: -2.75. The plan section of the consultation read, "1) Specs [spectacles/eyeglasses,] Current Rx [prescription] OK 2) Monitor for decreased VA [visual acuity.] 3) Continue present medications, artificial tears,, Monitor w [with] f/u [follow up.]" The 8/23/21 optometry note indicated she "presented with the following problems (s): blurred vision, Check cataracts, itchy eye." It indicated her visual acuity without correction was OD: 20/70 and OS: 20/70. The plan section of the consultation read, "1) Monitor for Decreased VA. 2) Continue Present Medications, Artificial Tears, Lid Hygiene, Monitor." An interview was conducted with Resident 40 on 8/22/22 at 1:59 p.m. She indicated she did not get artificial tears at the facility. An interview was conducted with the Interim DON (Director of Nursing) on 8/22/22 at 2:00 p.m. She indicated Resident 40 used to get eye drops, but no longer did. The Interim DON reviewed Resident 40's 2/21/22 optometry note and indicated she hadn't known her to be on any eye drops in the last 3 or 4 years that she'd worked there. An observation of the medication cart and interview was conducted with QMA (Qualified Medication Aide) 2 on 8/22/22 at 2:11 p.m. She searched the medication cart and was unable to locate any artificial tears for Resident 40. She indicated she'd never administered any eye drops to Resident 40. The physician's orders did not indicate a current		The SSD/Designee will request a list from the Eye Dr., at each visit, so that notes can be reviewed for new orders or requests. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Social Service Designee/Designee will audit each resident's chart that was seen by the eye doctor after each visit to ensure orders and requests were followed through x 6 months. Any missed items will be corrected and implemented immediately when noted. Findings will reported to the QAPI committed monthly during meetings. · by what date the systemic changes for each deficiency will be completed. 9/23/22	

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	order for artificial tears. An interview was conducted with the SSD (Social Services Director) on 8/23/22 at 9:49 a.m. She indicated Resident 40 had never worn glasses since she'd worked at the facility over the past year, and would contact the optometrist about the 2/21/22 note regarding the plan for eyeglasses. An interview was conducted with the SSD on 8/23/22 at 11:11 a.m. She indicated the optometrist didn't regularly meet with her when coming to the facility to discuss any new recommendations or plans. An interview was conducted with the optometrist on 8/23/22 at 12:10 p.m. He indicated Resident 40 had dry eye and was using artificial tears at some point, so he was recommending them to continue if she had further complaints. Resident 40 had a prescription for glasses and should be wearing glasses, if she wanted to do so. He ordered new glasses for her in July, 2020, but didn't recall following up to ensure they fit. He usually left new eye glasses with the SSD, but there was a problem in the facility with losing glasses. He was going to look into any further follow up to Resident 40 receiving her glasses and fax the information to the facility. On 8/26/22 at 2:20 p.m., upon facility exit, no further follow up information had been provided. The Ancillary Services policy was provided by the SSD on 8/23/22 at 11:19 a.m. It read, "It is the policy to provide services including but not limited to: podiatry, optometry, audiology, dental, and psych services to meet the residents highest physical social, and psychosocial well-being at the facility."			

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	3.1-39(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			

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	Based on interview and record review, the facility failed to provide appropriate treatment and services to prevent a resident with an indwelling urinary catheter from acquiring a urinary tract infection for 1 of 1 residents reviewed for urinary catheter care. (Resident 38) Findings include: The clinical record for Resident 38 was reviewed on 8/22/22 at 10:21 a.m. Resident 38's diagnoses included, but not limited to, major depressive disorder, anxiety disorder, and disorder of the kidney and ureter. Resident 38's annual MDS (Minimum data set) dated 8/1/22 indicated, he was cognitively intact and required extensive assistance of one person for personal hygiene. Resident 38's current care plan was reviewed. There was no care plan related to an indwelling urinary catheter. An interview with Resident 38 conducted on 8/22/22 at 10:23 a.m. indicated, the facility was not performing his urinary catheter care as often as it was ordered. A physician's order dated 1/26/22 indicated, to provide Foley (an indwelling urinary catheter) catheter care and to check placement every shift. A physician's order dated 2/26/22 indicated, to change the Foley catheter monthly during the night shift on the 26th. This order was discontinued on 3/26/22. A physician's order dated 4/26/22 indicated, to change the Foley catheter monthly during the	F 0690	**F690** The facility does provide appropriate treatment and services to prevent residents with an indwelling urinary catheter from acquiring urinary tract infections · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 38 catheter care was performed and catheter checked for placement. His indwelling urinary catheter was changed per his orders. His care plan has been updated to reflect an indwelling foley catheter. Resident 38 now receives catheter care, catheter placement checks, catheter changes and medication as ordered. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; On 9/15/11 the MDS coordinator completed an audit to ensure any other Residents that have an indwelling catheter order were being provided care as ordered.. No other Residents identified. · what measures will be put into place and what systemic changes will be made to ensure	09/23/2022

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	night shift on the 26th. Resident 38's March and April 2022 MARs (medication administration record) indicated, on the following dates and shifts, the Foley catheter care was left blank: 3/8/22 - evening shift 3/13/22 - evening shift 3/17/22 - evening shift 3/18/22 - day shift 3/23/22 - evening shift 3/24/22 - evening shift 3/27/22 - day shift 3/28/22 - day and evening shift 4/4/22 - evening shift 4/11/22 - night shift 4/13/22 - night shift 4/14/22- evening shift 4/17/22- evening shift 4/19/22- night shift 4/21/22- evening and night shift A nurses note dated, 4/23/2022 at 2:33 p.m. indicated, "Resident has been asleep and in bed pretty much all morning and afternoon. When the resident does wake up his words are slurred some[sic] but resident just falls back to sleep after a word or two." A skilled evaluation note dated 4/23/2022 at 2:37 p.m. indicated, Resident 38 vocalized he had lower back pain that was "achy", and was rated a 6 out of 10 on the pain scale. "Resident is alert and oriented with some lethargy today. Resident has mostly been asleep today. Resident is currently laying[sic] down still sleeping. When we wake the resident he answers some questions but then falls back to sleep. Resident has been having difficulty sleeping at night lately. So we have let the resident lay[sic] down and sleep. Will continue to		that the deficient practice does not recur; All licensed nursing staff were educated on the guidelines for preventing urinary tract infections policy on 9/19/22, including providing care and treatment as ordered. The MDS coordinator or designee will complete a daily audit Monday -Friday x 6 months to identify any Resident catheter care concerns. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The MDSC/Designee will audit the Mar/Tar for each resident with an indwelling urinary catheter daily x 1 month, then weekly x 1 month and then monthly x 4 months to ensure care is being provided as ordered. Non-compliance will be addressed with further education and/or disciplinary action as needed. Findings will be reported by the MDSC at the monthly QAPI meetings. . · by what date the systemic changes for each deficiency will be completed 9/23/22	

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	monitor resident." A nursing note dated, 4/23/2022 at 5:20 p.m. indicated, "I thought he was more tired than normal and slept most of the days because he has been depressed and not sleeping well at night. Then[sic] went to speak with the resident when he was more alert and he was having a hard time finding the correct words to say. Resident has been mumbling and stuttering more than normal and confused as well. Resident spoke with me about 30 mins[sic, minutes] ago and then had the therapist speak to him and he did not remember speaking with me. Spoke with[sic, physician's nurse's name] nurse and she said to send out the ED[sic, emergency department] since he has Chronic kidney issues." A nursing note dated 4/23/2022 at 5:56 p.m. indicated, "Called 911 and let them know what was going on. [sic, local hospital's name] ED [sic] was also called at 1741[sic, 5:41 p.m.] and a report was made to the triage nurse..." A nursing note dated 4/24/2022 at 6:48 a.m. indicated, Resident 38 returned from the hospital with a new script for an antibiotic. A hospital discharge summary dated 4/24/22 at 1:37 a.m. indicated, Resident 38's diagnoses were altered mental status and acute urinary tract infection. A physician's order dated 4/24/22, indicated, to give Resident 38 a 500 mg cephalexin(an antibiotic) capsule by mouth after meals for the urinary tract infection until 5/1/22. Resident 38's April 2022 MAR was reviewed. On the following dates and times, the MAR was left			

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	blank for the administration of cephalexin capsule: 4/24/22 - 6 p.m. dose 4/25/22 - 8 a.m., 1 p.m. and 6 p.m. doses 4/27/22 - 6 p.m. dose 4/29/22 - 8 a.m., 1 p.m. and 6 p.m. doses 4/30/22 - 8 a.m., 1 p.m. and 6 p.m. doses The April MAR also indicated the Foley catheter change was not completed and was coded as "2" which according to the chart code legend was "drug refused". Resident 38's July and August 2022 MARs were reviewed. On the following dates and shifts, the MAR was left blank for Foley catheter care provided: 7/1/22 - evening shift 7/2/22 - day and evening shifts 7/3/22 - evening shift 7/4/22 - night shift 7/5/22 - day and night shift 7/6/22-7/9/22 - evening shift 7/11/22 - night shift 7/12/22 - evening and night shifts 7/13/22 - evening shift 7/18/22-7/23/22 - evening shifts 7/26/22-7/28/22 - evening shift 8/6/22 - evening and night shift 8/7/22-8/8/22 - evening shifts 8/10/22 - evening shift 8/13/22 - evening shift 8/14/22 - night shift 8/15/22 - evening shift 8/17/22 - night shift 8/19/22 - evening shift 8/21/22 - day shift An interview with MDS conducted on 8/25/22 at 10:26 a.m. indicated, the facility does not have a permanent DON (Director of Nursing) but, when they did have a DON they would usually look			

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	back behind the nurses' charting and ensure both the charting and medication administration was completed. MDS indicated, she cant explain what happened on the days the MAR's were left blank. A Urinary Catheter Care policy was received on 8/25/22 at 10:21 a.m. from MDS. The policy indicated, "Documentation 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(s) giving the catheter care. 3. All assessment data obtained when giving catheter care. 4. Character of urine... 5. Any problems noted at the catheter-urethral junction during perineal care... 6. Any problems or complaints made by the resident related to the procedure. 7. How the resident tolerated the procedure. 8. If the resident refused the procedure, the reason(s) why and the intervention taken... Reporting 1. Notify the supervisor if the resident refuses the procedure..." A Guidelines for Preventing Urinary Tract Infections (Catheter-Associated) policy was received on 8/29/22 at 10:23 a.m. from ADM (Administrator). It indicated, "It is the responsibility of the interdisciplinary team to maintain vigilant practices to prevent CAUTIs [sic, catheter associated urinary tract infection] and to recognize and report early identifications that a CAUTI [sic] may be developing..." 3.1-41(a)(2)			

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F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to ensure the use of the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week; and to designate a registered nurse to to serve as the Director of Nursing (DON) on a full-time basis. This had the potential to affect 40 of 40 residents who resided at the facility. Findings include: A staffing schedule by department for the time period of 8/16/22 to 8/31/22 was received on 8/22/22 at 11:02 a.m. from ADM (Administrator). The schedule provided indicated, the interim DON was scheduled to work on the following days during the time period: 8/20/22 - evening shift 8/21/22 - evening shift 8/22/22 - evening shift 8/27/22 - evening shift 8/29/22 - evening shift	F 0727	It is the standard of the facility to have adequate RN coverage and to have an RN designated to serve as the Director of Nursing · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were found to have been affected by this alleged deficient practice · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were found to have been affected by this alleged deficient practice	09/23/2022

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	The schedule did not reflect a full-time schedule for DON. An interview with QMA (Qualified Medication Assistant) 2 was conducted on 8/26/22 at 10:43 a.m. QMA 2 indicated, she creates the staffing schedule for the nursing staff. She indicated, the interim DON gives her the days and shifts she is available and stated the interim DON's "schedule is her choice". An interview with ADM conducted on 8/26/22 at 11:40 a.m. indicated, the facility has an interim DON and she works full-time hours. When asked about the scheduled days and hours for the DON, she indicated, the schedule is just a "base" schedule and that the DON also picks up shifts from the pick up list. ADM stated, the facility had lost some registered nurses (RN) and presently the interim DON was the only RN at the facility. ADM admitted, some days the facility does not have any RN coverage, but she was "not sure how often that happens". ADM stated, NC (nurse consultant) had picked up shifts for RN coverage as well all though she was unable to provide a record of when NC had picked up shifts for RN coverage. An interview with NC conducted on 8/26/22 at 11:50 a.m. indicated, she had not picked up shifts at the facility for RN coverage in a "very long" time. NC indicated, she is currently the interim DON for a sister facility as the sister facility does not have a DON in place. A copy of DON's time sheet was provided by ADM on 8/26/22 at 12:41 p.m. It indicated, DON worked the following dates and hours/day: 8/1/22 - 9.21 hours 8/4/22 - 9.2 hours		The facility has been and is currently advertising and interviewing for a “permanent” Director of Nursing and RNs to fill the required positions. The facility will ensure the designated DON is working full-time hours and that there is an RN scheduled at least 8 consecutive hours per day, including weekends. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility has been and is currently advertising and interviewing for a “permanent” Director of Nursing and RNs to fill the required positions. The facility will ensure the designated DON is working full-time hours and that there is an RN at least 8 consecutive hours per day, including weekends. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Administrator/Designee will monitor the schedule for 6 months and ensure the designated DON is working full time hours and that an RN was scheduled at least 8 consecutive 8hrs per day, including week-ends.	

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	8/6/22 - 10.14 hours 8/7/22 - 9.41 hours 8/8/22 - 10.06 hours 8/12/22 - 3.51 hours 8/13/22 - 9.28 hours 8/15/22 - 9.49 hours Interim DON did not work full-time hours nor did the facility have RN coverage for at least 8 hours a day, 7 days a week. 3.1-17(b)(3) 3.1-17(b)(4)		Non-compliance will be addressed immediately when noted and corrections made. The Administrator will report findings at the monthly QAPI meeting. · by what date the systemic changes for each deficiency will be completed. 9/23/22	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, interview, and record review, the facility failed to track behaviors and timely update behavior care plans for 1 of 2 resident reviewed for behaviors (Resident 23). Findings include: The clinical record for Resident 23 was reviewed on 8/23/22 at 10:42 p.m. The Resident's diagnosis included, but were not limited to, schizophrenia and anxiety.	F 0740	The facility does track behaviors and updates behavior care plans in a timely manner · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 23 behavior care plan was updated and behaviors are now tracked when observed. · how other residents having	09/23/2022

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	155807	A. BUILDING 00 B. WING	08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	A care plan, initiated 3/13/18, indicated Resident 23 had psychotic behaviors of delusions and hallucination such as believing she is on fire, that her toes have been removed, or that she has died in her room. She also has a history of seeing or smelling things that are not present such as smoke. The goal was that her delusional beliefs or hallucinations would not cause distress to herself or others. The interventions which were initiated 3/13/18, included to allow one on one time as appropriate, give medications as ordered, offer for her to participate in activities, reassure her that she is okay and not in danger, redirect her with conversations about her past, and provide psychiatric services and medication management. A care plan, initiated, 3/13/18, indicated Resident 23 had a history of making false statements, claims, and accusations against staff and peers such as someone burned her or made threats against her. The goal was that she would refrain from making false accusations. The interventions which were initiated 3/13/18, included to allow one on one time as appropriate, approach in a calm and friendly manor, administer medications as ordered, psychiatric services, re-orient as needed, and report any accusations the administrative staff for investigation. A care plan, initiated 3/13/18, indicated Resident 23 had a potential to demonstrate verbally abusive behaviors related to her schizophrenia. The goal was that she would have no episodes of angry outbursts and would allow staff to cue and assist her as needed. The interventions which were initiated on 3/18/18, included to intervene when she became agitated and guide away from the source of distress, acknowledge her requests and attempt to meet them promptly, approach her in a calm positive manner, if she became irritated or		the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; On 9/16/22 the Social services director completed an audit of the behavior book of behaviors and behavior care plans, no other Residents were identified. On 9/14/22 the Social services director was educated on behavior management policy. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff in-serviced on documenting behaviors in the behavior tracking book when a behavior is observed on 9/19/22 · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The social services director or designee will monitor the behavior book daily Monday - Friday x 6 months for all new behaviors and all new behaviors that must be care planned. The SSD/Designee will also observe to ensure tracking documentation is taking place for known behaviors.	

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	angry allow her to calm down the reapproach, praise her when patience is demonstrated, and give positive feedback for good behaviors. A care plan, initiated 3/13/18, indicated Resident 23 had a history of verbal and physical aggression toward others, such as hitting, grabbing, throwing things, belittling others, derogatory statements, and racial slurs due to having poor impulse control. She has been hospitalized for hitting others and throwing items and having a urinary tract infection. The goal was for her aggression to be redirected. The interventions included, but were not limited to, when first signs of frustration are exhibited ask her how staff can help and provide assistance, initiated 4/3/18, If behaviors escalate, remove from source of agitation and offer to take walk with her or a snack using a calm approach, initiated 4/3/18, place on 1:1 as needed, initiated 4/2/18, observe for signs and symptoms of depression, anxiety, increased incidents of sudden mood changes and notify the nurse practitioner as needed, initiated 1/27/21. An Annual MDS (Minimum Data Set) Assessment, completed 6/14/22, indicated that she was cognitively intact. She displayed verbal behaviors directed toward others 1 to 3 times during the 7-day assessment period. She had displayed behaviors not directed toward others 1 to 3 times during the assessment period. Her behaviors had worsened since the previous MDS Assessment. On 8/23/22 at 9:23 a.m., the Administrator provided Resident 23's behavior management plan. The behavior management record indicated her identified behaviors were screaming, yelling, cursing, throwing self on the floor, attempting to tie cords around her neck, hiding items under her		Non-compliance will be corrected with further education and/or disciplinary action. The SSD will report findings to the QAPI committee monthly, during meetings. · by what date the systemic changes for each deficiency will be completed. 9/23/22	

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	clothing, removing clothing, and sudden changes in mood. The record had behaviors documented as occurring on 6/2/22, 6/8/22, and 8/3/22. On 8/23/22 at 11:21 a.m., Resident 23 was observed yelling out in dining area. She was removed from the area by the activity staff. On 8/23/22 at 12:11 p.m., Resident 23 was observed yelling out at another resident and telling him to get away from her. She was removed from the area by the activity staff During an interview on 8/23/22 at 2:55 p.m., QMA (Qualified Medication Aide) 4 indicated Resident 23 displayed behaviors such as yelling out, several times a day. She displayed delusions at times such as thinking someone has killed her or her mother. She has said someone is hurting her while she is sitting with no one around her. The staff try to redirect her with soda or chips and talk with her to get her mind off of things. The behaviors should be charted on the behavior management record when they occur. They should be documented each time they occur so that the social worker would have a clear record of what was happening. If the behaviors are not documented the no one would know what has gone on. On 8/23/22 at 9:23 a.m., the Administrator provided the Behavior Management Policy, revised December 2015, which read "...Residents in long term care facilities may exhibit puzzling and troublesome behaviors. The behaviors may become difficult to handle for staff and may involve other residents.... The staff should assess the behaviors and document in a quantitive manner, to assist in determining whether the behaviors can be addressed in the facility or			

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	whether outside assistance may be needed...The SSSD [sic]/SSW[sic]/ Designee is responsible for maintaining updated Care Plans on resident with identified behaviors and/or orders for psychotropic medications. The CP [sic] will include identified behaviors and interventions to redirect the behaviors. Updates should be made as often as needed...All staff are responsible for documentation on the Behavior Monitoring Form and identifying interventions initiated to redirect behaviors... 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.			

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	§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to ensure medications were available for 2 of 8 residents reviewed for medication administrations. (Resident's 20 and 31) Findings include: 1. The clinical record for Resident 31 was reviewed on 8/23/21 at 12:35 p.m. The diagnosis for Resident 31 included, but was not limited to, anxiety disorder. A physician order dated 3/19/22 indicated 40 milligrams (mg) of vilazodone was to be administered to Resident 31 once daily for anxiety. The August 2022 Medication Administration Record (MAR) for Resident 31 indicated on 8/23/22, the resident's vilazondone was not available to be administered. 2. The clinical record for Resident 20 was reviewed on 8/22/22 at 10:49 a.m. The diagnoses included, but were not limited to, frontotemperal dementia (it affects behavior and language), cognitive communication deficit, major depressive disorder, anxiety disorder, dementia with behavioral disturbances, bipolar disorder, and Obsessive-Compulsive Disorder.	F 0755	The facility does ensure medications are available for medication administrations · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 20 and Resident 31's missing medications were re-ordered and are now administered as ordered. . · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The MDS coordinator completed a medication administration audit on 9/15/22 for all residents. Any other concerns were addressed. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	09/23/2022

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	A physician order dated 11/16/21 indicated 25 mg of losartan was to be administered once a day for hypertension. A physician order dated 11/16/21 indicated 25 mg of metoprolol was to be administered once a day for hypertension. The August 2022 MAR for Resident 20 indicated the resident's 25 mg of lorsartan was not available to be administered on the following days: 8/17/22, 8/18/22, 8/21/22, 8/22/22 and 8/23/22. The MAR indicated the 25 mg of metoprolol was not available to be administered on 8/23/22. During observations of medication administrations with Qualified Medication Aide (QMA) 4 on 8/23/22 at 8:51 a.m., QMA 4 was observed at 9:03 a.m., pulling medications for Resident 20. During that time, QMA 4 was unable to locate the resident's 25 mg of losartan and 25 mg of metoprolol. At that time, QMA 4 indicated the lorsartan and the metoprolol was reordered on 8/22/22 due to out of supply. On 9:16 a.m., she was observed pulling Resident 31's medications. The resident's 40 mg of vilazodone was not available to be administered due to out of supply. An interview was conducted with QMA 4 on 8/23/22 at 9:20 a.m. She indicated the resident's medications are delivered from the pharmacy on medication cards. The last medication card available to the resident she writes "reorder" on the card to indicate the medication needs to be reordered when the supply was low. It was sometimes missed and not reordered timely. An interview was conducted with Minimum Data Set (MDS) Coordinator on 8/25/22 at 10:53 a.m. She indicated the pharmacy delivers medications		All licensed nurses and qualified medication aides were in-serviced on 9/19/22 on the facility medication administration policy. The medication administration record will be reviewed daily Monday-Friday by the MDSC/Designee to ensure daily compliance- non-compliance will be addressed with further education and/or disciplinary action as needed. Daily audit will occur x 1 month, then weekly x 2 months and then Every other week x 3 months. The MDSC will report findings to the QAPI committee monthly. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; · by what date the systemic changes for each deficiency will be completed 9/23/22	

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	twice a day. The staff should be ordering the medications when the supplies get low in the system. The pharmacy at times does not send. An "Ordering Medications from the Pharmacy" policy was provided by the Regional Director of Clinical Operation (RDCO) on 8/26/22 at 11:09 a.m. It indicated "...2. Repeat medications (refills) are written on a medication order form/ordered by peeling the reorder tabs from the prescription label and placing it in the appropriate area on the order form provided by the pharmacy for that purpose or requested via the facility's EHR [electronic health record] system and ordered as follows:...b. The refill order is called in, faxed, sent electronically or otherwise transmitted to the pharmacy. When available and legible, the pharmacy label (including bar-code) is pulled and transmitted to the pharmacy..." 3.1-25(a) 3.1-25(g)(3)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have			

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	access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure expired medications were not in the active supply within the medication cart and to destroy expired medications timely for 1 of 2 medication carts and 1 of 1 medication rooms throughout the facility. Findings include: An observation was made on 8/23/22 at 12:31 p.m. with LPN (Licensed practical nurse) 1 during medication pass. LPN 1 was preparing to administer insulin and had opened her medication cart. The following was observed in the medication cart: - A Lantus (long acting insulin) vial for Resident 16 with an opened date of 7/21/22 - A Lantus vial for Resident 14 with an opened date of 7/22/22 - A Lantus vial for Resident 20 with an opened date of 7/22/22 - A Lantus vial for Resident 32 with an opened date of 7/22/22 An interview with LPN 1 conducted at the same time as the observation on 8/23/22 indicated, insulin pens and vials once opened, were considered expired after a month and must not be	F 0761	The facility does ensure expired medications are not in the active supply within the medication cart and are destroyed timely · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The expired medications were immediately removed from the cart and expired medications destroyed. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were affected by this practice The licensed nurse on duty completed an audit on 9/15/22 of each medication cart and medication room of all expired medications.	09/23/2022

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	used one month after its opened date. An observation of the medication room was conducted on 8/26/22 at 11:07 a.m. with LPN 1. During the observation, the following was noted on top of a bin on the counter top: - A blister pack of Senna (stool softener) 8.6 mg tablets which contained 25 tablets had an expiration date of 6/20/22 for Resident 10. - Two blister packs of hyoscyamine(medication used to treat stomach/intestinal problems) 12 mg tablets which one pack contained 30 tablets and the other pack contained 29 tablets had an expiration date of 7/19/22 for Resident 5. - A blister pack of hyoscyamine 12 mg tablets which contained 8 tablets had an expiration date of 5/24/22 for Resident 5. A Storage of Medication policy was received on 8/24/22 at 2:13 p.m. from ADM (Administrator). The policy indicated, "Procedures...7. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal and reordered from the pharmacy...Expiration Dating (Beyond-use dating)...3. Certain medication or package types, such as IV[sic, intravenous] solutions, multiple dose injectable vials,...once opened, require and expiration date shorter than the manufacturer's expiration date to insure[sic] medication purity and potency...5. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated...7. No expired medications will be administered to a resident. 8. All expired medications will be removed from the active supply and destroyed in the facility regardless of amount remaining."		· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Licensed nurses and QMA's were in-serviced on the medication storage and destruction policy on 9/19/22 The night shift licensed nurse on duty will be responsible to complete a weekly check of all medication carts and rooms for expired medications and/or medications that need to be destroyed on Wednesdays. Medications will be destroyed when found. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Admin/Designee will inspect the medication carts and medication rooms for expired medications and medications that need destroyed, weekly x 1 month, every other week x 2 months and then monthly x 3 months · by what date the systemic changes for each deficiency will be completed. 9/23/22	

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	The FDA (Food and Drug Administration) website, last accessed on 8/30/22, titled "Information Regarding Insulin Storage and Switching Between Products in an Emergency" indicated, "According to the product labels from all three U.S. insulin manufacturers, it is recommended that insulin be stored in a refrigerator at approximately 36 degrees to 46 degrees Fahrenheit. Unopened and stored in this manner, these products maintain potency until the expiration date on the package. Insulin products contained in vials or cartridges...may be left unrefrigerated at a temperature between 59 degrees and 86 degrees Fahrenheit for up to 28 days." 3.1-25(k) 3.1-25(0) 3.1-25(r)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on interview and record review, the facility failed to obtain laboratory tests, as ordered, for 2 of 5 residents reviewed for unnecessary medications. (Residents 1 and 39) Findings include: 1. The clinical record for Resident 1 was reviewed	F 0770	The facility does ensure laboratory tests are obtained as ordered for unnecessary medications · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	09/23/2022

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	on 8/25/22 at 11:00 a.m. The diagnoses included, but were not limited to: chronic kidney disease, vascular dementia, type 2 diabetes, hypertension, seizures, and hyperlipidemia. The physician's orders indicated to obtain the following laboratory tests every 3 months in March, June, September, and December, effective 3/4/22: CBC w/diff (complete blood count with differential,) Keppra level, CMP (complete metabolic panel,) ammonia level, VPA (valproic acid) level, and A1C (blood test that measures your average blood sugar level over past 3 months.) The most recent CBC w/diff, Keppra level, BMP (Basic Metabolic panel,) ammonia level, VPA level, and A1C results were provided by the MDS (Minimum Data Set) Coordinator on 8/25/22 at 11:38 a.m. These laboratory tests were collected and reported on 9/1/21. The facility was unable to provide lab results for these tests from March, 2022 or June, 2022. 2. The clinical record for Resident 39 was reviewed on 8/22/22 at 1:29 p.m. Resident 39's diagnoses included, but not limited to, type II diabetes mellitus, hemiplegia affecting right side, pulmonary embolism (blood clot in the lungs), and schizophrenia. A physician's order dated 6/25/21 indicated, to obtain a CBC with differential (complete blood count), CMP (complete metabolic profile) A1C (blood glucose average test), fasting lipid (cardiovascular disease screen), and vitamin D level to be performed every 6 months. A Consultant Pharmacist Recommendations to Nursing Staff dated 7/5/22 indicated, Resident 39 "has several routine labs ordered in PCC [sic, electronic health record] that are overdue. Please		Resident 1 and Resident 39 labs were ordered and obtained on 9/21/22 · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The regional nursing consultant completed a labs audit; any concerns identified were addressed. This alleged deficient practice has the potential to affect all residents with laboratory tests ordered. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; On 9/19/22 all licensed nurses were educated on the laboratory services policy. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place The MDSC/Designee will audit 5 charts per week x 2 months then 5 charts monthly x 4 months to ensure laboratory compliance is being met. Non-compliance will be corrected immediately and staff will be re-educated and/or disciplined as needed. The MDSC will report findings to the qAPI	

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	155807	A. BUILDING 00 B. WING	08/26/2022

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	obtain." A dietary note dated 8/23/2022 at 3:28 p.m. indicated, "Resident was due for follow up HGA1C[sic, hemoglobin A1C] in April or May but no result in record - please obtain result. An interview with NC (nurse consultant) conducted on 8/25/22 at 11:57 a.m. indicated, she was unable to locate the results for Resident 39's routine labs (CBC, CMP, vitamin D, HgA1C, fasting lipid panel) which were to be done every 6 months. 3.1-49(a)		committee monthly during meetings. · by what date the systemic changes for each deficiency will be completed. 9/23/22	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional			

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	standards for food service safety. Based on observation, interview, and record review, the facility failed to label refrigerated food with date prepared or opened and to have shelving present in the freezer to allow for ventilation of frozen foods affecting 40 of 40 residents residing at the facility. Findings include: On 8/22/22 at 8:15 a.m., the facility kitchen was observed with the DM (Dietary Manager). The refrigerator contained an undated sandwich on a plate wrapped in plastic wrap, 2 bottles of salsa with no open date, a gallon jug of grape drink with no open date and a bottle of sweet and sour sauce with no date opened. There was an open package of bologna, with the bologna exposed to air and an open package of sausages wrapped in plastic wrap, which was dated 8/8/22. The small upright freezer was observed to have multiple bags of frozen foods stacked on the floor extending halfway up the freezer. There was 1 shelf available for food storage in the small freezer. The large freezer was observed to bags and boxes of frozen food stacked on the floor and on top of each other without shelving. During an interview on 8/22/22 at 8:25 a.m., the DM indicated that all items should be dated when they are put in the refrigerator. The package of sausages were pulled from the freezer on 8/8/22 and thawed in the refrigerator. The freezer shelves had been removed because the clips which held the shelves had broken. The maintenance department was aware that new clips were needed for the shelving.	F 0812	The facility does label refrigerated food with date prepared or opened and has shelving present in the freezer to allow for ventilation of frozen foods. · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were found to be affected by this alleged, deficient practice All food/drink items with no dates or not properly labeled/stored were disposed of Shelving has been replaced in the freezer and frozen foods no longer stored on the floor of freezer · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The dietary manager completed an audit of the freezer and refrigerator of all unlabeled and dated food. No other concerns identified. No residents were found to be affected by this alleged, deficient practice · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	09/23/2022

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	On 8/26/22 at 11:23 a.m., the RDCO (Regional Director of Clinical Operations) provided the Storage of Foods under Sanitary Conditions Policy, updated June 2018, which read "... 1. All food items stored in the refrigerator must be labeled and dated if not scheduled to be served at the next meal. 2. All food items should be placed in seamless containers with tight fitting lids. 3. Leftover foods should be placed in an approved storage container and should be discarded after 3 days...6. Food should not [sic] stored directly on the floor..." 410 IAC 7-24-177 Food storage Sec. 177. (a) Except as specified in subsections (b) and (c), food shall be protected from contamination by storing the food as follows: (1) In a clean, dry location. (2) Where it is not exposed to splash, dust, or other contamination. (3) At least six (6) inches above the floor. (4) In a manner to prevent overcrowding. (5) In packages, covered containers, or wrappings. (b) Food in packages and working containers may be stored less than six (6) inches above the floor on case lot handling equipment. (c) Pressurized beverage containers, cased food in waterproof containers, such as bottles or cans, and milk containers in plastic crates may be stored on a floor that is clean and not exposed to floor moisture. (d) For purposes of this section, a violation of subsection (a)(1), (a)(2), (a)(3), (a)(4), (b), or (c) is a noncritical item. (e) For purposes of this section, a violation of subsection (a)(5) is a critical or noncritical item based on the determination of whether or not the violation significantly contributes to food contamination, an illness, or an environmental		All dietary staff were educated on 9/19/22 of the storage, labeling and dating policy. The freezer clips were ordered. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The dietary manager or designee will complete a daily audit x 1 month and then weekly x 5 months of each refrigerator and freezer for unlabeled and dated food, improperly wrapped food and food storage in the freezer. The DM will report findings of the audits during the monthly QAPI meeting. The Administrator/Designee will complete a weekly inspection of all dietary refrigerators and freezers to check for improperly labeled, wrapped and stored foods for 1 month and then monthly x 5 months. The Administrator will report findings during the monthly QAPI meeting · by what date the systemic changes for each deficiency will be completed. 9/23/22	

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	health hazard. 3.1-21(i)(3)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and 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			

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	be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and 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 was maintained with hand hygiene usage and cleaning and disinfecting of a glucometer	F 0880	The facility does ensure infection control is maintained with hand hygiene usage and cleaning and disinfection of glucometers.	09/23/2022

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	during medication administrations observations for 5 of 8 residents observed. (Residents' 8, 17, 20, 37 and 32) Findings include: 1. The clinical record for Resident 17 was reviewed on 8/23/21 at 12:30 p.m. The diagnosis for Resident 17 included, but was not limited to, Schizophrenia. 2. The clinical record for Resident 37 was reviewed on 8/23/21 at 12:35 p.m. The diagnosis for Resident 37 included, but was not limited to, vascular dementia without behavioral disturbance. 3. The clinical record for Resident 20 was reviewed on 8/22/22 at 10:49 a.m. The diagnoses included, but were not limited to, frontotemperal dementia (it affects behavior and language), cognitive communication deficit, major depressive disorder, anxiety disorder, dementia with behavioral disturbances, bipolar disorder, and Obsessive-Compulsive Disorder. An observation was made of medication administrations with Qualified Medication Aide (QMA) 4 on 8/23/22 at 8:51 a.m. QMA 4 was observed pulling medications for Resident 17 from the medication cart. During that time, QMA 4 was observed touching the medication cards and medication cups. After, she went into Resident 17's room and placed the medication cup in Resident 17's hands. Then left the room and returned to the medication cart. There was no observation of hand hygiene observed prior or after the medication administration. She then was observed pulling Resident 20's medications. After, she went to Resident 20's room and handed him the medication cup. She then left the		· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents 17, 37 and 20 now receive their medication from staff who have practiced proper hand hygiene during medication passes. Residents 8 and 32 now receive blood glucose checks from glucometers that have been properly disinfected after each use · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All resident's receiving medications and/or blood glucose checks via glucometer usage are at risk for this alleged deficient practice. No other residents noted to have been affected. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All QMAs and Licensed nurses were educated on the cleaning of blood glucose meter and hand	

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	resident's room and returned to the medication cart. There was no observation of hand hygiene observed prior or after the medication administration. QMA 4 was then observed pulling Resident 37's medications. After, she went into Resident 37's room and administered the medication cup to the resident. She was observed touching the resident's hands, wheelchair handles, picked up a soda can off the floor and discarded it. QMA 4 left the resident's room and utilized hand hygiene at that time. There was no observation of hand hygiene prior to the administration. An interview was conducted with Regional Director of Clinical Operations (RDCO) on 8/26/22 at 10:39 a.m. QMA 4 should performed hand hygiene after each resident's medication administration. A hand hygiene policy was provided by the Administrator on 8/23/22 at 10:29 a.m. It indicated "...Preventing the spread of infection...Residents can be exposed to potentially pathogenic organisms in several ways, including but not limited to the following: Improper hand hygiene;...Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene:..before and after direct resident contact..." A medication administration policy was provided by the RDCO on 8/26/22 at 10:40 a.m. It indicated "...2. Handwashing and Hand Sanitization: The person administering medications adheres to good hand hygiene, which includes washing hands thoroughly: a) before beginning a medication pass, b) prior to handling any medication, c) after coming into direct contact		hygiene during medication pass on 9/19/22 · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The MDSC or designee will observe 5 medication passes and 5 blood glucose checks with a glucometer weekly x 1 month then 5 of each every other week x 5 months. Non compliance will be corrected immediately when noticed and staff re-educated at the time. MDSC will report findings to the QAPI committee meeting monthly. · by what date the systemic changes for each deficiency will be completed. 9/23/22	

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	with a resident..." 4. The clinical record for Resident 8 was reviewed on 8/25/21 at 12:30 p.m. The diagnosis for Resident 8 included, but was not limited to, diabetes mellitus. 5. The clinical record for Resident 32 was reviewed on 8/25/21 at 12:00 p.m. The diagnosis for Resident 32 included, but was not limited to, type 2 diabetes mellitus. An observation was made of obtaining blood sugar readings with QMA 3 on 8/25/22 at 10:58 a.m. QMA 3 was observed donning on gloves and picking up a lancet, alcohol wipe and the glucometer machine to obtain Resident 8's blood sugar reading. During that time, she was observed pricking Resident 8's finger. After, she wiped the glucometer machine with an alcohol wipe. She then was observed obtaining Resident 32's blood sugar reading by using the same glucometer. QMA 3 pricked Resident 32's finger and obtained a blood sugar reading from the glucometer. She then cleaned the glucometer with an alcohol wipe. An interview was conducted with QMA 3 on 8/25/22 at 11:03 a.m. She indicated she used either alcohol wipes or germicidal wipes to disinfect the glucometer. An interview was conducted with License Practical Nurse (LPN) 1 on 8/25/22 at 11:06 a.m. She indicated she used germicidal wipes to disinfect the glucometer, but alcohol wipes could also be used. An interview was conducted with Regional Director of Clinical Operations (RDCO) on 8/26/22 at 10:39 a.m. The glucometer should be disinfected			

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	with germicidal wipes. The "Professional Monitoring Blood Glucose Meter Owner's Manual" was provided by the Minimum Data Set (MDS) Coordinator on 8/26/22 at 10:30 a.m. It indicated "...Caring for [name of meter]...Meter Care, Cleaning and Disinfecting Cleaning removes blood and soil from the meter. Disinfecting removes most, but not all possible infectious agents (bacteria or virus) from the meter, including blood-borne pathogens...To Clean and Disinfect the Meter:...2. Make sure meter is off and a test strip is not inserted. With only Super Sani-Cloth Wipes (or any disinfectant product with the EPA [Environmental Protection Agency] reg. no. of 9480-4), rub the entire outside of the meter using 3 circular wiping motions with moderate pressure on the front, back, left side, right side, top and bottom of the meter...3. Using fresh wipes, make sure that all outside surfaces of the meter remain wet for 2 minutes...Note: Other disinfectants have not been tested. The effect of other disinfectants used interchangeably has not been tested with the meter. Use of disinfectants other than Super Sani-Cloth Wipes may damage meter..." 3.1-18(b)(l)			
F 0881 SS=F Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §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)(3) An antibiotic stewardship program that includes antibiotic use protocols			

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	and a system to monitor antibiotic use. Based on observation, interview and record review, the facility failed to implement the facility's surveillance system to track antibiotic usages. This had a potential to effect 40 of 40 residents that reside in the facility. Findings include: An interview was conducted with License Practical Nurse (LPN) 1 on 8/26/22 at 10:26 a.m. She indicated she was the Infection Control Preventionist, but she does not track the antibiotic usage in the facility. An observation was made with the Regional Director of Clinical Operations (RDCO) and the Minimum Data Set (MDS) Coordinator of the antibiotic stewardship binder on 8/26/22 at 10:39 a.m. The binder did not include documentation of monitoring and tracking of antibiotic usage on January 2022, February 2022, March 2022, April 2022, May 2022, June 2022, July 2022, August 2022, September 2021, October 2021, November 2021, December 2021. An interview was conducted with the RDCO on 8/26/22 at 10:54 a.m. She indicated she was unable locate documentation antibiotic usage was being tracked. The sheets in the binder were blank. The infection control policy was provided by the Administrator on 8/23/22 at 10:29 a.m. It indicated "...The facility collects, analyzes, and uses data related to infections, to identify and prevent the spread of infections and to adjust its infection prevention and control program..." The "Antibiotic Stewardship - Review an Surveillance of Antibiotic Use and Outcomes"	F 0881	The facility has implemented a surveillance system to track antibiotic usage · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were found to have been affected by this alleged deficient practice. ATB usage tracking is now being completed. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were found to have been affected by this alleged deficient practice. ATB usage tracking is now being completed. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All nursing staff have been in-serviced as of 9/19/22 on the Antibiotic stewardship tracking program. All current ATB have been added to the antibiotic stewardship tracking program. The night shift licensed charge nurse will be responsible to	09/23/2022

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	policy indicated "...Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship...4. all resident antibiotic regiments will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: a. Resident name and medical record number; b. Unit and room number; c. Date symptoms appeared; d. Name of antibiotic..., e. start date of antibiotic; f. pathogen identified..., g. site of infection; h. date of culture; i. stop date; j. total days of therapy; k. outcome; and l. adverse events..."		complete a daily audit of any new atb to ensure all have been added to the antibiotic stewardship tracking binder. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The MDSC/Designee will request a monthly pharmacy report of antibiotic usage and compare each month to the facility antibiotic tracking binder. The binder will be updated as needed. MDSC will report findings to the QAPI committee monthly · by what date the systemic changes for each deficiency will be completed. 9/23/22	
F 0914 SS=D Bldg. 00	483.90(e)(1)(iv)(v) Bedrooms Assure Full Visual Privacy §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. Based on observation and interview, the facility	F 0914	The facility does provide a privacy curtain in rooms shared by 2	09/23/2022

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	155807	A. BUILDING 00 B. WING	08/26/2022

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RURAL HEALTH CARE CENTER	1747 N RURAL ST INDIANAPOLIS, IN 46218

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	failed to provide a privacy curtain in a room shared by 2 residents for 2 of 2 residents reviewed for privacy (Residents 7 and 23). Findings include: 1a. The clinical record for Resident 7 was reviewed on 8/22/22 at 11:04 a.m. The Resident's diagnosis included, but were not limited to, depression and schizophrenia. 1b. The clinical record for Resident 23 was reviewed on 8/23/22 at 9:23 a.m. The Resident's diagnosis included, but were not limited to, anxiety and schizophrenia. During an interview on 8/22/22 at 11:06 a.m., Resident 7 indicated there was no privacy curtain in between herself and her roommate. The room was the therapy gym before she had been moved to it. There was a track for one in the middle of the room. On 8/25/22 at 2:25 p.m., Resident 7 and Resident 23's room was observed to have no privacy curtain present in the room. During an interview on 8/25/22 at 2:45 p.m., LPN 1 indicated she had not noticed there was not a privacy curtain in the room and that there should be one present. 3.1-19(l)(6) 3.1-19(l)(7)		residents · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents 7 and 23 privacy curtain was installed. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The Administrator completed an audit to ensure all rooms have a privacy curtain installed, with no new findings. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The maintenance director will complete a weekly audit of all rooms to ensure that all privacy curtains are attached and hanging properly. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The audit findings will be reviewed by the Maintenance Dir/Designee during the monthly facility QAPI	

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			meeting x 6 months. · by what date the systemic changes for each deficiency will be completed. 9/23/22	
F 0919 SS=D Bldg. 00	483.90(g)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. Based on observation, interview, and record review, the facility failed to have a functional call light in a bathroom affecting 3 of 4 residents who use that bathroom (Residents 17, 20, and 26). Findings include: During an interview on 08/22/22 at 9:51 a.m., Resident 17 indicated the call light on the wall in the bathroom would not turn on when he pulled the string. On 8/22/22 at 9:55 a.m., the bathroom shared by Residents 17, 20, and 26 was observed. The call light would not turn on when the string was pulled. On 8/26/22 at 11:18 a.m., the shared bathroom of Resident 17, 20, and 26 was observed with the Housekeeping Supervisor. She indicated that the call light did not come on when the string was pulled. It should function when the string was	F 0919	The facility does have a functional call lights in bathrooms · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents 17, 20, and 26 call lights have been fixed as of 9/19/22. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The interim maintenance director completed an audit of all call lights within the facility with no other concerns identified. · what measures will be put into place and what systemic	09/23/2022

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	pulled. On 8/26/22 at 1:09 p.m., the Regional Director of Clinical Operations provided the Call Light Policy and Procedure, dated September 2014, which read "...Policy: The Resident's call light is to be within reach of the dependent Resident and answered promptly. The purpose is to respond to the Resident's requests and needs...7. If call light is defective, report immediately to maintenance...Equipment: Functioning call light..." 3.1-19(u)		changes will be made to ensure that the deficient practice does not recur; The maintenance director/designee will check all call lights weekly. Areas of concern will be corrected promptly · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Admin/Designee will randomly select 5 rooms per week x 2 months to check the working status of call lights then 5 rooms monthly x 4 months. The Administrator will report findings to the QAPI committee monthly. · by what date the systemic changes for each deficiency will be completed. 9/23/22	
F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional and sanitary environment in the kitchen and the storage area adjoining the kitchen, with the potential to	F 0921	The facility does maintain a functional and sanitary environment in the kitchen and the storage area adjoining the kitchen. · what corrective action(s) will be accomplished for those	09/23/2022

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	affecting 40 of 40 residents who reside at the facility. Findings include: On 8/22/22 at 8:15 a.m., the facility kitchen was observed with the DM (Dietary Manager). The hand washing sink was pulling away from the wall and tubing from the ice machine to the drain was present in the crack between the handwashing sink and the wall. The floor in the kitchen had cracked ceramic tiles with a dirty build-up present in the cracks. There was a black film present on from the cove base extending onto the flooring behind the ice machine and under the hand wash sink. The door frames by the dishwashing area and refrigerator were rusted and broken off extending from the floor approximately 6 inches up the door frames. The storage area, adjacent to the kitchen, where dishes and the bread were stored, had a hole in the wall by the back door, which was at the top portion of the door, where the hydraulic door closer was located. There was unpainted dry wall present on the ceiling by the back door which had brown stains from water damage. There were holes in the drywall which were brown in color and the paper covering of the drywall had dark brown, jagged openings with the paper covering pointing downwards into the room. The back door in the storage area which adjoined the kitchen was open and the screen door was also propped open to the outdoors. The kitchen staff were observed washing a large garbage can out with a hose just outside of the open doors. A gnat was noted flying in the dish room area. During an interview on 8/22/22 at 8:40 a.m., the DM indicated that the hole in the wall and the dry wall on the ceiling had been that way "for a		residents found to have been affected by the deficient practice; The hand washing sink has been secured to the wall and tubing from the ice machine is no longer in a crack The cracked ceramic tiles in the kitchen floor have been repaired The black film is gone from the cove base Door frames by the dishwashing are and refrigerator have been repaired The hole in the wall in the storage area has been repaired The ceiling tiles with water damage have been corrected Holes in the drywall have been repaired as well as the paper covering of the drywall The back door in the kitchen and screen doors are no longer propped open The black grime has been removed from the floor around the vending machines Dust has been cleaned from the ceiling vent outside of the kitchen door The DR floor has been cleaned and cracks repaired Gauze removed from bottom leg of table in Dining room Broken tiles at doorway near the refrigerator have been repaired The soft drywall has been corrected The Dining room and hallway floors have been scrubbed	

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	while". The last time it had rained they had used buckets to contain the water which dripped through the ceiling. On 8/22/22 at 8:15 a.m., the facility dining room was observed. The floor at the vending machines was noted to have black grime. The ceiling vent outside of the kitchen door was covered with a blackish layer of dust. The open food carts, filled with breakfast trays which contained plates covered with plastic domes with holes in them and glasses of uncovered orange juice were sitting under the dirty vent. The floor in the dining room had a black/grey appearance and cracks in several of the floor tiles. A table sitting in back corner of the dining room, by a window, had kerlix (gauze dressing) wrapped around the bottom leg of the table. On 8/25/22 at 11:42 a.m., the facility kitchen was observed with the DM. Broken tiles were noted at the doorway by the refrigerator. The drywall, where the tiles should have been, was soft to touch. The back door was not closed all the way and a large black cricket was noted on the floor in the doorway of the storage area and the dishwashing area. The cricket was immediately removed from the kitchen area. On 8/25/22 at 3:00 p.m., the facility dining room floor was observed to have a red stain on the floor and the floor appeared dingy. During an interview on 8/25/22 at 11:50 a.m., the DM indicated that the tiles had been missing from the wall by the refrigerator for quite a while. The ceramic tiles on the kitchen floor did collect dirt and should be replaced. The wall tiles also needed replaced. The cricket most likely got into the kitchen from the back door which was not		The vent in the middle of the DR was cleaned and fastened to the ceiling No residents were noted to have been affected by this practice. The facility has ordered a new buffer as of 9/19/22 and is awaiting shipment. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No residents were noted to have been affected by this practice. The hand washing sink has been secured to the wall and tubing from the ice machine is no longer in a crack The cracked ceramic tiles in the kitchen floor have been repaired The black film is gone from the cove base Door frames by the dishwashing are and refrigerator have been repaired The hole in the wall in the storage area has been repaired The ceiling tiles with water damage have been corrected Holes in the drywall have been repaired as well as the paper covering of the drywall The back door in the kitchen and screen doors are no longer	

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	shut properly and had a gap at the bottom. On 8/26/22 at 8:44 a.m., the hallway floors and dining room floors were observed to be dingy and dirty around the tables. There was red stain of paint on the floor. The vent in the middle of the dining room was observed to have a black dust layer present and to be pulling out of the ceiling, with anchor brackets visible. On 8/26/22 at 11:18 a.m., an environmental round was conducted with the HKS (Housekeeping Supervisor) and the MS (Maintenance Supervisor). The vent in the middle of the facility dining room was observed with the MS. He indicated the drywall on the ceiling was becoming "soft" and that the anchors used for the screws which held up the vent had pulled away. It needed repaired and that the dust layer present on the vent should be cleaned. The cove base on the dining room wall which backed up to the kitchen area had a dark, blackish stain present along the wall. The HKS indicated that the drain on the other side of the wall in the kitchen had clogged, which caused the water from the kitchen to back up and come under the wall into the dining room. The area along the cove base was stained due to the water issues and needed to be cleaned. The floors in the facility were dingy. The floor buffer had been broken for around a month and the housekeeping staff had not been able to deep clean and buff the floors due to it being broken. They did need a deep cleaning. 3.1-19(f)		propped open The black grime has been removed from the floor around the vending machines Dust has been cleaned from the ceiling vent outside of the kitchen door The DR floor has been cleaned and cracks repaired Gauze removed from bottom leg of table in Dining room Broken tiles at doorway near the refrigerator have been repaired The soft drywall has been corrected The Dining room and hallway floors have been scrubbed The vent in the middle of the DR was cleaned and fastened to the ceiling · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The housekeeping supervisor has been in-serviced by the Administrator on providing a safe/functional/sanitary and comfortable environment on 9/19/22. The Housekeeping Supervisor will be responsible to do daily rounds when on duty to observe for necessary environmental concerns. Concerns will be addressed promptly. · how the corrective action(s)	

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Administrator/Designee will make daily rounds of the facility when on duty, for 1 month and then weekly thereafter. The appropriate staff will be notified of concerns promptly. The Administrator will report findings of rounds to the QAPI committee each month during meeting. · by what date the systemic changes for each deficiency will be completed. 9/23/22	
F 0925 SS=F Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview, and record review, the facility failed to have an effective pest control to control insects in the building affecting 40 of 40 residents residing at the building. Findings include: On 8/22/22 at 8:00 a.m., the facility nursing station was observed. In the corner of the nurse's station was a gold-colored pole which had dead bugs adhered to it hanging from the ceiling.	F 0925	The facility does have an effective pest control to control insects · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility has ordered a new gnat protection system as of 9/19/22 and is awaiting shipment. The dead bugs have been removed from the gold-colored pole at the nursing station The black cricket on the floor in	09/23/2022

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	On 8/22/22 at 8:15 a.m., the facility kitchen was observed with the DM (Dietary Manager). The back door in the storage area which adjoined the kitchen was open and the screen door was also propped open to the outdoors. The kitchen staff were observed washing a large garbage can out with a hose just outside of the open doors. A gnat was noted flying in the dish room area. On 8/22/22 at 9:41 a.m., Residents 20 and 37's room was observed. There was a gnat flying in the room. During an interview on 8/22/22 at 9:41 a.m., Resident 20 indicated that he did have gnats in his room at times. On 8/22/22 at 9:51 a.m., Residents 17 and 26's room was observed to have a gnat flying in the room. During an interview on 8/22/22 at 9:51 a.m., Resident 17 indicated he did have gnats fly in his room and he thought they sprayed for them. On 8/22/22 at 10:47 a.m., Residents 28 and 40's room was observed. Gnats were flying around the room. On 8/25/22 at 11:42 a.m., the facility kitchen was observed with the DM. Broken tiles were noted at the doorway by the refrigerator. The drywall, where the tiles should have been, was soft to touch. The back door was not closed all the way and a large black cricket was noted on the floor in the doorway of the storage area and the dishwashing area. The cricket was immediately removed from the kitchen area. On 8/26/22 at 9:23 a.m,, the Regional Director of		the doorway of the kitchen storage area was swiftly removed · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The facility has ordered a new gnat protection system as of 9/19/22 and is awaiting shipment. The dead bugs have been removed from the gold-colored pole at the nursing station The black cricket on the floor in the doorway of the kitchen storage area was swiftly removed what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Dietary staff were in-serviced by (who) on (date) to not leave doors open and/or propped in the kitchen The housekeeping supervisor has been in-serviced by the Administrator on providing a safe/functional/sanitary and comfortable environment on 9/14/22. The Housekeeping Supervisor will be responsible to do daily rounds when on duty to observe for necessary environmental concerns, including excessive pests. . Concerns will	

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	Clinical Operations provided the Pest Control Invoice, dated 7/26/22, which indicated light crawling insect activity found in interior. During an interview on 08/26/22 at 11:40 a.m., the Housekeeping Supervisor indicated the facility did have a gnat problem. The gnats came through the drains. She poured cleanser down the drains weekly, and the pest control company did come to the facility weekly. She was unaware that the back door to the kitchen was being left open. The door in the kitchen should not be left open and would not help the problem. 3.1-19(f)(4)		be addressed promptly. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Administrator/Designee will make daily rounds of the facility when on duty, for 1 month and then weekly thereafter. The appropriate staff will be notified of concerns promptly. The Administrator will report findings of rounds to the QAPI committee each month during meeting. · by what date the systemic changes for each deficiency will be completed. 9/23/22	