STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00427694. This visit was in conjunction with the Investigation of Complaint IN00428904. Complaint IN00427694 - No deficiencies related to the allegations are cited. Survey dates: February 19, 20, 21, 22, 23, 26, 2024 Facility number: 000164 Provider number: 155263 AIM number: 100289550 Census Bed Type: SNF/NF: 31 Total: 31 Census Payor Type: Medicare: 3 Medicaid: 19 Other: 9 Total: 31 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 1, 2024.	F 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses to regulatory obligations. The facility requests plan of correction be considered our allegation of compliance effective 3/26/2024 to the state findings of the Recertification and State Licensure Survey. We respectfully request paper compliance in leu of a post survey review. Please contact the facility if additional information is needed for a desk review.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility	F 0641	F641	03/26/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandi Gladish	HFA	03/14/2024

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

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	failed to ensure an accurate Minimum Data Set (MDS) Assessment was completed for 3 of 5 residents reviewed for unnecessary medications. The MDS Assessment indicated one resident received a diuretic and one resident received an opioid during the lookback period when they didn't. The MDS Assessment indicated one resident was not on an antibiotic but they were. (Resident 15, Resident 27, Resident 4) Findings include: 1. On 2/21/24 at 2:24 P.M., Resident 15's clinical records were reviewed. Resident 15 was admitted on 10/19/23. Diagnosis included, but were not limited to, polyneuropathy, diabetes mellitus, major depressive disorder, generalized anxiety disorder, chronic pain syndrome, and pulmonary hypertension. The most current quarterly MDS Assessment, dated 12/26/23, indicated Resident 15 was cognitively intact, needed extensive assistance of two for bed mobility, and transfers and total dependence of two for toilet use. The medications listed were insulin 7 days, antipsychotic, antianxiety, opioid, antiplatelet, and hypoglycemic. Current Physician Orders included but were not limited to the following: risperidone Oral Tablet Give 0.25 mg by mouth two times a day related to altered mental status, delusional disorders dated 12/12/2023 Humalog Injection Solution 100 UNIT/ML (Milliliters) (Insulin Lispro) Inject 10 units subcutaneously with meals for diabetes dated 12/12/2023		It is the practice of this facility to ensure MDS Assessments accurately reflect resident's status. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. Resident #15 MDS was revised to reflect no opioid medication. b. Resident #27 MDS was revised to reflect no diuretic medication. c. Resident #4 MDS was revised to reflect antibiotic medication during assessment lookback period. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents who have the potential to be affected by the alleged deficiency. An audit was conducted. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. In-service held by the Regional MDS Consultant on 3/15/2024 for the MDS Coordinator and the following was reviewed: RAI Manual -specific to accuracy of assessments related to	

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	Humalog Injection Solution 100 UNIT/ML (Milliliters) (Insulin Lispro) Inject 20 units subcutaneously one time related to type II diabetes mellitus. Start date 12/22/23 Furosemide Oral Tablet 20 MG (milligrams) Give 20 mg by mouth one time a day related to pulmonary hypertension, essential hypertension dated 10/20/2023 Aspirin EC (Enteric Coated) Low Dose Oral Tablet Delayed Release 81 MG Give 81 mg by mouth one time a day related to peripheral vascular disease dated 10/20/2023 Lantus Solostar Subcutaneous Solution Pen Injector 100 mg/ml Inject 40 units subcutaneously one time a day related to type II diabetes mellitus. Start date 12/13/23 D/C (discontinue) date 12/22/23 Lantus Solostar Subcutaneous Solution Pen Injector 100 mg/ml Inject 25 units subcutaneously two times a day related to type II diabetes mellitus Start date 12/22/23 D/C date 12/28/23 Valium Oral Tablet 5 mg Give 5 mg by mouth one time only for pre-MRI (Magnetic Resonance Imaging) anxiety for one day Give 30-45 minutes before MRI Start date 12/20/23 Tramadol HCL (Hydrochloride) Oral Tablet 50 mg Give 1 tablet by mouth every 6 hours as needed for pain related to chronic pain syndrome for 30 days Start date 12/26/23 On 2/22/24 at 10:58 A.M., review of the MAR (Medication Administration Record) indicated Resident 15 did not receive an opioid during the lookback period of 12/19/23 through 12/26/23.		medication coding with diuretics, opioid, and antibiotic medication coding. MDS coding and accuracy of assessments. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. A performance improvement tool has been initiated that randomly audits five (5) residents to ensure that patient's MDS Assessment is accurately completed to accurately reflect resident's status. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools.	

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	2. On 2/21/24 at 10:28 A.M., Resident 27's clinical records were reviewed. She was admitted on 8/16/23. Diagnosis included, but were not limited to, Alzheimer's disease, coronary artery disease (CAD), hypertension, renal insufficiency, renal failure, anxiety disorder, depression (other than bipolar), and schizoaffective disorder. The most current Quarterly MDS Assessment, dated 12/27/23, indicated Resident 27 was unable to be assessed for cognitive status, needed limited assistance of one for bed mobility, transfers and toilet use. The medications listed were antipsychotic, antianxiety and diuretic. Current Physician Orders included but were not limited to the following: Lasix Oral Tablet 20 MG (Furosemide) Give 1 tablet by mouth every 24 hours as needed for swelling related to edema Dated 10/11/2023 Paliperidone ER Oral Tablet Extended Release 24 Hour 6 MG Give 6 mg by mouth one time a day related to schizoaffective disorder Dated 12/5/2023 Xanax Oral Tablet 0.25 MG (Alprazolam) Give 0.25 mg by mouth three times a day related to anxiety disorder 9 A.M.,1 P.M.,7 P.M. Dated 9/20/2023 Resident 27's MAR (Medication Administration Record) was reviewed from 12/20/23 through 12/27/23. The MAR did not indicate Lasix was given-ordered Lasix 20 mg 1 every 24 hours as needed. During an interview on 2/23/24 at 11:38 A.M., the MDS Coordinator indicated she had been marking the medications in the MDS Assessment if a medication had been ordered but not necessarily			

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	given. 3. On 2/22/24 at 6:26 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, moderate dementia with behavioral disturbances and pneumonia. The most recent Quarterly MDS Assessment, dated 2/8/24, indicated Resident 4 was cognitively intact, needed supervision of staff for bed mobility, transfers, and toileting, and the resident had not been on an antibiotic during the 7 day look back period. The February 2024 MAR was reviewed and indicated Resident 4 was administered Cefdinir 300 mg (milligrams) twice daily for 7 days and Clindamycin 300 mg three times a day for 7 days beginning on 2/1/24. During an interview on 2/23/24 at 11:45 A.M., the MDS Coordinator indicated he should have had antibiotics marked on the recent MDS because he took the two antibiotics during the look back period and it was not marked in error. During an interview on 2/23/24 at 11:38 A.M., the MDS Coordinator indicated there was not a policy, but they use the RAI (Resident Assessment Instrument) Manual.			
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and			

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

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	Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 4 of 12 residents reviewed in the sample. Care plans were not developed for a resident doing household chores and residents with weight loss/nutrition, dementia, and behaviors. (Resident 24, Resident 1, Resident 4, Resident 26) Findings include: 1. On 2/19/24 at 9:45 A.M., Resident 24 was observed sweeping the facility floor outside of the activity room. On 2/20/24 at 2:24 P.M., Resident 24's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behavioral disturbance and anxiety. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 12/7/23, indicated Resident 24's cognition was severely impaired and she was a limited assist of 1 staff for bed mobility, transfers, and toileting. Resident 24's clinical record lacked an order to do household chores. Resident 24's clinical record lacked assessments to do household chores. Resident 24's clinical record lacked a care plan to do household chores. During an interview on 2/23/24 at 10:17 A.M., the DON (Director of Nursing) indicated Resident 24 asked to help staff with cleaning. It was her choice and she was up "ad lib" (on her own) so he was not aware there needed to be an order,	F 0656	F656 It is the practice of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. Resident #24 Care plan was revised to ensure it accurately reflects corrected mobility, and transfers. An assessment to do household chores was completed. An order for residents to complete household chores was submitted to MD and charted in EMR. Care plans were developed for residents to do household chores. b. Resident #1 a nutritional care plan was developed, implemented, and reflects resident's current needs. c. Resident #4 care plan was developed, implemented, and reflects resident's current behaviors. d. Resident # 26 care plan was developed, implemented, and reflects resident's medical diagnosis of dementia. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents who have the	03/26/2024

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	assessment, and care plan for the resident to do household chores in the facility. During an interview on 2/26/24 at 11:40 A.M., the DON indicated the facility bought her a broom to use and it was kept in the soiled utility room with the staff's cleaning supplies. Housekeeping/staff gave her the broom when she asked for it. At that time, he indicated there may not be a policy on having an order, assessment, and care plan to do household chores. 2. On 2/21/24 at 12:25 P.M., Resident 1 was observed in the dining room with CNA (Certified Nurse Aide) 4 assisting her to eat. On 2/21/24 at 10:58 A.M., Resident 1's clinical record was reviewed. Resident 1 was admitted on 1/9/24. Diagnoses included, but were not limited to, dementia with behavioral disturbance and weight loss. The most recent Admission MDS Assessment, dated 1/16/24, indicated Resident 1's cognition was severely impaired, she was an extensive assist of 2 staff for bed mobility, transfers, toileting, limited assist of 1 staff for eating, and her height was 58 inches. Current Physician's Orders included, but were not limited to, the following: Weekly weight every day shift every Friday for 4 weeks, ordered 2/16/2024 House shake BID (twice daily) with lunch and supper, ordered 2/15/2024 Regular diet, mechanical soft texture, thin consistency and ground meats/assist with feeding, ordered 1/10/2024		potential to be affected by the alleged deficiency. An audit was conducted. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. The facility will implement a weekly schedule for care plan reviews and updates, ensuring involvement from the interdisciplinary team. b. Staff will receive additional training on the importance of accurate and comprehensive care planning as well as on any changes to the care planning process. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. A performance improvement tool has been initiated that randomly audits five (5) residents to ensure that patient's Care plans are accurately completed to accurately reflect resident's status. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by	

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	Patient to be placed on a mechanical soft diet with thin liquids. Staff should remind the patient to use swallowing compensatory strategies (small bites/sips, thorough mastication [chewing] of the [food]bolus, reduced rate of intake, alternate between eating and drinking) while participating in P.O. (by mouth) intake to promote safety, ordered 1/10/2024 The clinical record lacked a care plan for nutrition. Resident 1's weights (in wheelchair) since admission included: On 1/9/24 at 1: 41 P.M., 99.4 lbs (pounds) On 1/16/24 at 10:58 A.M., 97.6 lbs (weight loss of 1.8 lbs in 7 days) On 1/23/24 at 9:36 A.M., 96.4 lbs (weight loss of 3 lbs in 14 days) On 1/30/24 at 10:58 A.M., 90.6 lbs (weight loss of 8.8 lbs in 21 days) On 2/1/24 at 12:59 P.M., 91.4 lbs (weight loss of 8.0 lbs in 23 days) On 2/6/24 at 11:41 A.M., 93.4 lbs (weight loss of 6.0 lbs in 28 days) On 2/16/24 at 12:52 P.M., 90.4 lbs (weight loss of 9 lbs in 38 days) Progress notes included, but were not limited to, the following: On 2/15/2024 at 12:58 P.M., "Nutrition/Dietary Note: Reviewed chart. CBW [calculated body weight]: (2/6/24) 93.4# [pounds], BMI [body mass index] 19.5 (WNL) [within normal limits], wt [weight] loss of 6# x [for]1 month (6%). Resident receives a regular, mechanical soft with ground meat diet with thin liquids. Resident consumes average 49% at meals. No difficulty chewing or swallowing reported. Resident receives diuretic daily; wt fluctuation expected. Recommend: 1.		the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools.	

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	weekly wts x 4 weeks to ensure wt stabilizes, 2. house shake bid [twice daily]. RD [Registered Dietician] available prn [as needed]." During an interview on 2/23/24 at 10:38 A.M., the DON indicated Resident 1 did have weight loss since she admitted to the facility. At that time, he indicated he kept a handwritten "at risk" book in his office to keep track of residents that need to be monitored, monthly weights, the notifications made, and dietician consulted. After the dietician saw Resident 1 about a week ago, she ordered protein supplements and weights. The staff assisted her to eat and cued her to eat. Food preferences were discussed at admission with the dietary manager. He was not aware that Resident 1 did not have a care plan for nutrition and indicated the MDS Coordinator, who was newly hired, was expected to do the nursing care plans. 3. On 2/22/24 at 6:26 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, moderate dementia with behavioral disturbances and Alzheimer's. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 2/8/24, indicated Resident 4 was cognitively intact, had dementia, and needed supervision of staff for bed mobility, transfers, and toileting. The clinical record lacked a specific care plan for dementia and related behaviors. During an interview on 2/23/24 at 10:58 A.M., the Director of Nursing (DON) indicated Resident 4 had a diagnosis of dementia and related behaviors. At that time, he indicated the MDS Coordinator, who was newly hired, was expected to do the nursing care plans and the Social			

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	Services Director (SSD) was expected to do care plans related to behaviors. He was not aware that there was not a dementia care plan for Resident 4. During an interview on 2/23/24 at 12:01 P.M., the SSD indicated since the MDS Coordinator position was not filled by someone long term, they have not been able to keep up with the care plans and she could see that a specific care plan for dementia and related behaviors for Resident 4 would be helpful. 4. On 2/19/24 at 10:52 A.M., Resident 26 was observed in the front lobby playing an activity with other residents and activity staff. On 2/21/24 at 12:29 P.M., Resident 26's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II and low back pain. The most recent Quarterly MDS Assessment, dated 2/7/24, indicated Resident 26 was cognitively intact, a limited assist of 1 staff for bed mobility, transfer, and toileting, and physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred 1-3 times in the 7 day look back period. The clinical record lacked current physician's orders to monitor for behaviors. The clinical record lacked a care plan for behaviors. Progress notes included, but were not limited to, the following: On 12/29/2023 at 2:40 P.M., "Nurse's Note: resident made a inappropriate comment of a sexual			

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	nature toward another female resident in the facility. that res [resident] was not offended or upset by the comment. I discussed the comment with the resident both residents stated that the comment was in jest. I asked not to make such comments as it was inappropriate in the facility and people may not take that type of comment as a joke. [name of resident] voiced understanding and agreed not to repeat this type of joking with his peers." On 1/26/2024 at 12:52 P.M., "Nurse Practitioner Note: ... Long term resident of Sycamore seen for psychiatric assessment of restlessness and agitation, continued assessment of moods, changes in behaviors, efficacy of psychotropic medications, monitoring of possible side effects and review of labs related to psychotropic medications. Patient transferred from a previous facility per patient's request to Sycamore in October 2023. Psychiatric evaluation requested due to staff reports of patient behaviors of making inappropriate comments to staff and other residents. Staff also reported that patient's previous roommate stated patient was "on pornography" on his phone and "talking" to the phone at night. Roommate had gotten up and moved to a different room in the middle of the night because this behavior disturbed him. Patient states that he doesn't know why his roommate changed rooms in the middle of the night. Patient stated the only way his roommate would have known patient was on inappropriate sites on his phone was because his roommate had looked at patient's cell phone. Patient denies ever having said anything inappropriate to staff or other residents. Patient states that he is looking to get into an assisted living apartment currently as he is ready to be on his own. Discussed with patient that discretion with his personal choices of what			

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	155263	A. BUILDING 00 B. WING	02/26/2024

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	he does on his phone is to be limited to his room only and not to be discussed with other. Also addressed that it is inappropriate to make sexual comments toward staff or other residents ... Plan 1. agitation. staff to provide support, call for any psych related question changes or concerns ... " On 2/3/24 4:35 P.M., "Nurse's Note: Resident told a CNA after another resident reported resident that yes something occurred. Resident was sitting in recliner in room this nurse entered room to interview resident on incident with another resident. Resident stated that something yes something had occurred. This nurse interviewed resident privately in room r/t incident. Resident told this nurse that about 1 week to 2 weeks ago resident walked other involved resident down to room to assist in finding room, while holding hands and resident followed other resident into room when a mutual kiss occurred when resident was exiting room. Resident was unable to notify this nurse of who initiated the kiss and resident expressed understanding of other resident having dementia. Resident stated that today's incident happened in this residents room not in hallway that other resident had entered private room where they talked, held hands, and yet again shared a mutual kiss which resident again would not say who may have initiated kiss but again expressed understanding of resident dementia he then stated following the kiss today he touched resident breast with his hand then he asked other resident to leave room so nothing further would occur even though he had no further plans. This nurse explained that the behavior/incident was not appropriate and requested this resident avoid other resident if possible. Resident had no further questions/concerns when this nurse was exiting room. Resident did request dinner be brought to his room that he was not coming out for the time			

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	being. All proper authority, MD [Medical Doctor], DON, admin [administrator], and other resident family member were notified. This resident was placed on 15min [minute] checks x [for]72hrs [hours]. Will continue to monitor resident r/t [related to]incident." On 2/13/24 at 6:03 P.M., "Nurse's Note: Reported to writer that resident was making inappropriate comments towards a staff member that works in the kitchen. Writer reported to DON about the situation." During an interview on 2/21/24 at 8:45 A.M., the DON indicated Resident 26 had known sexual behaviors. During an interview on 2/23/24 at 11:30 A.M., LPN (Licensed Practical Nurse) 3 indicated Resident 26 would make inappropriate comments sometimes and female nurses tried to be proactive. "If we aren't comfortable doing something (ie resident asked her to put lotion on his belly which he was capable of doing) we go to [name of DON] and he will do it." At that time, she indicated staff tried to keep their ears and eyes open at all times on Resident 26. During an interview on 2/23/24 at 10:40 A.M., the DON indicated Resident 26 came from sister facility and had behavior of complaining and burning bridges but he didn't know how bad it was. At that time, he indicated he had no idea about sexually inappropriate behaviors. The facility would keep him in a private room even though he wasn't care planned for it. Staff knew to watch Resident 26 and were told to let DON know if there was any care they were uncomfortable giving on day shift and when he was not available, the staff should do care in pairs			

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	although the resident was not care planned for that. He indicated the best thing was to give him his space and he wasn't sure if he would need to be care planned for the behaviors. The SSD (Social Services Director) would develop the care plans for behaviors. During an interview on 2/23/24 at 11:45 A.M., the MDS Coordinator indicated she was newly hired, and she has been trying to "catch them up". At that time, she indicated new orders and changes to the care plans should be updated every day after the morning meeting and as needed. She just hasn't had the time to make sure all care plans for all residents were up to date. She indicated there was not a template for dementia to use, so they usually used the "cognitively impaired template" and the SSD would add behaviors to it and each dementia resident should have a care plan specific to their needs. A resident with weight loss should have a nutrition care plan and a resident with known behaviors should also have a specific care plan for those she would think but that would fall under the SSD responsibility. During an interview on 2/23/24 at 12:06 P.M., the SSD indicated Resident 26 knew the difference between right and wrong. At that time, she indicated she was "on the fence" about writing a care plan for his behaviors. On 2/26/24 at 10:58 A.M., a current Care Planning Policy, revised September 2013, was provided by the DON and indicated " ... Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident ... " 3.1-35(a)			

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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 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 observation, interview and record review, the facility failed to revise the care plans for 3 of 7 residents reviewed for pressure ulcers and accidents. One resident had a change in condition, two residents had a change in mobility, and their care plans were not revised. (Resident 29, Resident 12, Resident 24) Findings include:	F 0657	F657 It is the practice of this facility that ensure care plans are developed, reviewed, and revised. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice:	03/26/2024

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	1. On 2/21/24 at 9:22 A.M., Resident 29 was observed sitting in a wheelchair in the common area at activities. On 2/21/24 at 2:09 P.M., Resident 29 was observed sitting in a wheelchair in the common area with a boot on his right foot and an alarm on the back of the wheelchair. On 2/22/24 at 1:19 P.M., Resident 29 was observed sitting up in a wheelchair with a wanderguard on his right wrist at an activity. On 2/23/24 at 9:26 A.M., Resident 29 was observed sitting up in a wheelchair at a table close to the nurse's desk one on one with an activity staff. He was wearing a boot on his right foot, a wanderguard on his right wrist and a chair alarm on the back of the wheelchair. On 2/22/24 at 11:39 A.M., Resident 29's clinical record was reviewed. He was admitted on 10/25/23. Diagnosis included but were not limited to, non-ST elevation (NSTEMI) myocardial infarction, diabetes mellitus with polyneuropathy, attention-deficit hyperactivity disorder, predominantly inattentive type, unspecified dementia, muscle weakness, unsteadiness on feet, and need for assistance with personal care. The most current Quarterly MDS Assessment and State Optional MDS (Minimum Data Set) Assessment, dated 12/8/23, indicated Resident 29 had severe cognitive impairment, needed limited assistance of one for bed mobility and toilet use, and supervision with transfers. Behaviors indicated Resident 29 had physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching,		a. Resident #24 Care plan was revised to ensure it accurately reflects correct mobility, and transfers to up ab lib. b. Resident #12 Care plan was revised to ensure it accurately reflects correct mobility, and transfer to assist of 2. c. Resident #29 Care plan was revised to ensure it accurately reflects resident's change in condition. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents who have the potential to be affected by the alleged deficiency. An audit was conducted. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. The facility will implement a regular weekly schedule for care plan reviews and updates, ensuring involvement from the interdisciplinary team. b. Staff will receive additional training on the importance of accurate and comprehensive care planning as well as on any changes to the care planning process. 4. How the corrective actions will	

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	grabbing, abusing others sexually) for 1-3 days. Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) for 1-3 days. Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) for 1-3 days. Resident wandered daily and had no alarms or restraints.. Current Physician Orders included but were not limited to the following: bed and chair alarms, check placement and function each shift, every day and night shift for decreased safety awareness Dated 2/17/2024 Offloading boot to R foot when out of bed r/t (related to) wound, every day and night shift for wound 2/9/2024 Place wanderguard and add to elopement record, check placement and function every shift, every day and night shift for wandering Dated 1/13/24 A care plan for Current Functional Performance, dated 10/26/2023 indicated the following: Bed mobility - Independent / No set-up or physical help Eating - Independent / set-up help only Toilet use - Independent / set-up help only Transfer - Independent / no set-up or physical help During an interview on 2/23/24 at 10:00 A.M., the DON (Director of Nursing) indicated Resident 29 was declining and had been for the last month. He was no longer wandering, but he still had a		be monitored to ensure the deficient practices will not occur: a. A performance improvement tool has been initiated that randomly audits five (5) residents to monitor the ongoing accuracy and completeness of resident's Care plans. This Quality Assurance Audit Tool will be completed by the Director of Nursing/Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools.	

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	wanderguard on. He needed assistance with care and transfers now and stayed in the wheelchair so he had a bed and chair alarm. During an interview on 2/23/24 at 11:23 A.M., the DON indicated if there was a change in a resident's condition, the care plan should be updated. 2. On 2/19/24 at 11:31 A.M., Resident 12 was observed in his room asleep in the recliner and there were non skid strips in front of his recliner. On 2/22/24 at 9:23 A.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, COPD, generalized (muscle) weakness, unsteadiness on feet, and abnormalities of gait and mobility. The most recent Quarterly MDS Assessment, dated 2/19/24, indicated Resident 12 was cognitively intact, and an extensive assist of 2 staff for bed mobility, transfers, and toileting. Current Physician's Orders included, but were not limited to, the following: Up with assist of 1, dated 4/6/2022 up with assist of 2, dated 2/22/24 A current Functional Performance Care Plan, dated 12/8/23, included, but was not limited to, the following interventions: Bed mobility- Independent/no set-up or physical help, initiated 12/8/23 Toilet use- Total assist/two person physical assist, initiated 12/8/23 Transfer- Total assist/two-person physical assist, initiated 12/8/23 A current Falls Care Plan, revised 2/8/24, included,			

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	but was not limited to, the following intervention: Assist of 2 staff with transfers, revised 2/22/24 A current Activities of Daily Living (ADL) Care Plan, revised 5/5/22, included, but was not limited to, the following intervention: Bed mobility: The resident requires extensive assist by two staff to turn and reposition in bed, revised 5/5/22 Toilet use: The resident requires extensive assist by two staff for toileting, revised 5/5/22 Transfer: The resident requires extensive assist by one staff to move between surfaces, revised 5/5/22 During an interview on 2/23/24 at 11:07 A.M., the DON indicated the order for assist of 1 was wrong because he was definitely an assist of two staff. The order, MDS Assessment, and care plan should all reflect that. At that time, he indicated nursing staff were educated on entering the mobility information into the electronic health record (EHR) so the MDS Assessment was accurate. If the resident's mobility changed, that was verbally reported between nursing staff during shift change and should be brought to the DON's attention. 3. On 2/19/24 at 9:45 A.M., Resident 24 was observed sweeping the facility floor outside of the activity room without staff's assistance. On 2/19/24 at 12:09 P.M., Resident 24 was observed walking in the West hall of the facility without staff's assistance. On 2/20/24 at 2:04 P.M., Resident 24 was observed in the front lobby walking around without staff's assistance.			

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	On 2/20/24 at 2:24 P.M., Resident 24's clinical record was reviewed. Diagnoses included, but were not limited to, dementia with behavioral disturbance and anxiety. The most recent Quarterly MDS Assessment, dated 12/7/23, indicated Resident 24's cognition was severely impaired and she was a limited assist of 1 staff for bed mobility, transfers, and toileting. Current Physician's Orders included, but were not limited to the following: up at lib (on own), dated 6/28/23 A current ADL Performance Care Plan, revised 1/21/24, included, but was not limited to, the following interventions: Transfers: The resident requires extensive assist by one staff to move between surfaces, dated 8/1/22 During an interview on 2/21/24 at 8:45 A.M., the DON indicated the resident's orders, MDS mobility, and care plans should match and "ad lib" means go without the staff's assistance which Resident 24 was capable of. He indicated the order was correct but the care plan was not. The MDS Coordinator, newly hired, was in charge of revising nursing care plans and because of turn over, the care plans have been missed and not been kept up to date. During an interview on 2/23/24 at 11:45 A.M., the MDS Coordinator indicated she was newly hired, and she has been trying to "catch them up". At that time, she indicated new orders and changes to the care plans should be updated every day after the morning meeting and as needed. She just hasn't had the time to make sure all care plans for all residents were up to date.			

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	On 2/26/24 at 10:58 A.M., a current Care Planning Policy, revised September 2013, was provided by the DON and indicated " ... Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident ... Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change ..." 3.1-35(d)(2)(B)			
F 0659 SS=D Bldg. 00	483.21(b)(3)(ii) Qualified Persons §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure a resident was transferred by qualified personal. An unlicensed staff member transferred a resident that resulted in a fall for 1 of 4 residents reviewed for falls. (Resident 12) Finding includes: On 2/19/24 at 11:31 A.M., Resident 12 was observed in his room asleep in the recliner and there were non skid strips in front of his recliner. On 2/22/24 at 9:23 A.M., Resident 12's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), generalized (muscle) weakness, unsteadiness on feet, and abnormalities of gait	F 0659	F659 It is the practice of this facility to ensure that services are provided by qualified people in accordance with each resident's written care plan. 1. What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a. Resident #12 Care plan was revised to ensure it accurately reflects corrected mobility, and transfer to show assist of 2. b. The activities assistant was educated immediately regarding his job description and scope of	03/26/2024

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	and mobility. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 2/19/24, indicated Resident 12 was cognitively intact, and an extensive assist of 2 staff for bed mobility, transfers, and toileting. Current Physician's Orders included, but were not limited to, the following: Up with assist of 1, dated 4/6/2022 up with assist of 2, dated 2/22/24 A current Functional Performance Care Plan, dated 12/8/23, included, but was not limited to, the following intervention: Bed mobility- Independent/no set-up or physical help, initiated 12/8/23 Toilet use- Total assist/two person physical assist, initiated 12/8/23 Transfer- Total assist/two-person physical assist, initiated 12/8/23 A current Falls Care Plan, revised 2/8/24, included, but was not limited to, the following intervention: Assist of 2 staff with transfers, revised 2/22/24 A current Activities of Daily Living (ADL) Care Plan, revised 5/5/22, included, but was not limited to, the following intervention: Bed mobility: The resident requires extensive assist by two staff to turn and reposition in bed, revised 5/5/22 Toilet use: The resident requires extensive assist by two staff for toileting, revised 5/5/22 Transfer: The resident requires extensive assist by one staff to move between surfaces, revised 5/5/22		practice. 2. How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents who have the potential to be affected by the alleged deficiency. An audit was conducted. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. The facility will ensure that all non-license staff members are in service during the orientation process on their job descriptions and scope of practice. b. The Director of Nursing and or designee will review reports of incidents and accidents to determine if a lack of qualifications or training may have contributed to the event. 3. What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. The facility will ensure that all non-license staff members are in service during the orientation process on their job descriptions and scope of practice. b. The Director of Nursing and or designee will review reports of incidents and accidents to determine if a lack of qualifications	

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	Progress Notes included, but were not limited to, the following: On 2/19/24 at 2:16 P.M., "Nurse's Note: Called to resident room by staff resident was being transferred to his recliner and was sat on the floor without hitting his head or sustaining injury. Assessed resident no visible s/s [signs/symptoms] of injury or pain. Assisted resident to recliner. Notified MD [Medical Doctor] and POA [Power of Attorney] of incident." On 2/19/24 at 2:18 P.M., "IDT [interdisciplinary team] note: Resident fell during transfer staff was attempting transfer from w/c [wheelchair] to recliner staff could not comp-lete [sic] the transfer and sat resident on the floor without injury. Immediate intervention was to educate staff on proper transfer procedure and scope of practice. Resident is a two assist but transfer was attempted by single staff. Education immediately completed. Cont [continue] all prev [previous] interventions as ordered. MD and POA notified of incident. Care plans reviewed and updated as needed." During an interview on 2/23/24 at 11:07 A.M., the DON (Director of Nursing) indicated on 2/19/24 Activities Assistant 5 attempted to transfer Resident 12 from his wheelchair to recliner in his room by himself. At that time, the DON indicated the resident was definitely an assist of 2 staff for transfers. He indicated the job description for activity staff was reviewed with Activities Assistant 5 and they were educated on practicing outside their scope of practice. During an interview on 2/26/24 at 10:25 A.M., Activities Assistant 5 indicated he did not know at the time that he was not supposed to transfer residents without being licensed or certified staff		or training may have contributed to the event. 4. How the corrective actions will be monitored to ensure the deficient practices will not occur: a. A performance improvement tool has been initiated to ensure that staff members' qualifications align with their job responsibilities and the service they provide. This Quality Assurance Audit Tool will be completed by the HR Director/Designee weekly x3 weeks, monthly for 3 months, then quarterly for 2 quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility Quality Assurance Program. Monitoring will continue as planned or will be increased by the Quality Assurance Committee if needed to obtain 100% compliance. Additional action will be taken by the Quality Assurance Committee if warranted based on the outcome of tools.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155263	A. BUILDING 00 B. WING	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYCAMORE CARE STRATEGIES	12802 EAST US HWY 50 LOOGOOTEE, IN 47553

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	member and he indicated he did not know the resident needed assist of 2 staff. On 2/23/24 at 12:00 P.M., a current non dated Activities Assistant Job Description, signed by the Activity Director on 11/11/23 that it was reviewed with the employee, was provided by the DON and indicated " ... Essential duties of our Activities Assistant include but are not limited to: ... keep abreast of current federal and state regulations, as well as professional standards ... Assure that established safety regulations are always followed ... " On 2/26/24 at 10:58 A.M., a current Job Description Policy, Revised August 2010, was provided by the DON and indicated " ... Department Directors are responsible for reviewing the job description with the employee during the employee's orientation process, when changes are made in the job description, and during annual performance and competency evaluations. Each employee is required to read and sign a copy of his/her respective job description prior to performing assigned tasks ... " 3.1-35(g)(2)			