STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	04/04/2023

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HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN 46552

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure survey. This visit included the Investigation of Complaint IN00402235. Complaint IN00402235. Federal/State deficiencies related to the allegations are cited at F656. Survey dates: March 27, 28, 29, 30, 31 & April 3 and 4, 2023 Facility number: 000427 Provider number: 155672 AIM number: 100275150 Census Bed Type: SNF/NF: 74 Residential: 44 Total: 118 Census Payor Type: Medicare: 5 Medicaid: 62 Other: 7 Total: 74 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed 4/20/2023.	F 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or			

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

Carlos Romero | Administrator | 05/30/2023

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	her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its			

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	admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to ensure the physician was notified of significant weight loss for 2 of 2 residents reviewed for nutrition. (Resident D & 7) and resident refusal to wear preventative equipment . (Resident D) Findings include: 1. The record for Resident 7 was reviewed on 3/30/2023 at 10:00 A.M. The diagnoses included but were not limited to: dementia with behavioral disturbances, anxiety disorder, and major depressive disorder. A Dietary Progress Note, dated 3/15/2023, indicated that she had a significant weight loss of 7.7% in 30 days and 10.5% in 180 days. A Care Plan, dated 4/18/2022, indicated to notify the physician and family if weight varies 5% in 30 days or 10% in 180 days. 2. A record for Resident D was on 3/29/2023 at 10:05 A.M. Diagnoses include, but were not limited to: edema, dementia with behavioral disturbances and history of bariatric surgery. A Dietary Progress Note, dated 2/15/2023, indicated that she had a significant weight loss of 8.9% at 90 days and 10.8% at 180 days. During an interview, on 3/31/2023 at 10:17 A.M., the Assistant Director of Nursing (ADON)	F 0580	The facility is alleged to be out of compliance by failing to ensure the physician was notified of significant weight loss for 2 of 2 residents reviewed for nutrition. (Resident D & 7) and resident refusal to wear preventative equipment. A. The physicians for residents D and & weight loss and for resident D for refusal to wear the preventive equipment. Obtained new order to discontinue medigrips for Resident D. Careplans were updated for all three residents. B. Audit was completed on all weight loss residents and residents with refusals to wear preventive equipment to determine if MDs had been notified. No other residents were identified C. Nursing staff were educated by the DON on MD notification and Change of Condition. D. An audit will be completed by the DON/designee for residents with weight loss or refusals three times a week for 4 weeks, twice a week for 4 weeks , weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	06/06/2023

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	indicated that they should have notified the Physician and the family after the dietitian made the recommendations and documented in the progress notes. 3. The record for Resident D was reviewed on 3/29/2023 at 10:05 A.M. Diagnoses included, but were not limited to: edema, dementia with behavioral disturbances and history of bariatric surgery. During an observation, on 3/27/2023 at 2:45 P. M., Resident D's, skin was swelling over the tops of her socks. During an observation, on 3/29/2023 at 9:45 A.M., Resident D was sitting at a dining room table wearing her shoes without any socks. Resident D's legs were swollen. During an observation, on 3/30/2023 at 8:58 A.M., she was sitting on the edge of her bed with both shoes on and one black sock on her left foot and no sock on her right, both legs swollen. A Physician's Order, dated 12/15/2022, indicated medigrips were to be applied every morning on night shift to bilateral (both) legs for edema. The Treatment Administration Record (TAR), dated March 2023, indicated the resident refused every day except for one day. The TAR, dated February 2023, indicated she refused every day. During an interview on 3/30/2023 at 2:05 P. M., the Assistant Director of Nursing (ADON) indicated that she should have had her medigrips on. The TAR indicated that she refused to wear them. and			

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	she would expect her staff to notify the physician after 3 refusals so he can decide the next course of treatment. On 3/31/2023 at 11:02 A.M., the Director of Nursing provided a policy titled, "Weight Management", revised 8/26/2020, and indicated the policy was the one currently used by the facility. The policy indicated "...8. Documentation: a. The physician should be informed of a significant change in weight and may order nutritional interventions. b. The family should be informed of a significant change in weight and any additional information regarding the resident's weight historically, likes and dislikes, possible interventions to encourage consumption and other input the family may have...." 3.1-5(a)			
F 0585 SS=E Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.			

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	§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing			

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	written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the			

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	grievance decision. Based on observation, record review and interview, the facility failed to ensure information on how to file a grievance was made available to residents and contact information of the grievance official was posted prominently. In addition, 6 of 6 alert and oriented resident attending the Resident Council meeting did not know how to access a grievance form. (Residents 19, 44, 48, 49, 61 and 67) Findings include: 1. During the Resident council meeting on 3/27/23 at 11:21 A.M., 6 of 6 alert and oriented residents indicated they did not know how to access a grievance form if they desired to submit a grievance. Two of the 6 residents indicated they were not aware of the facility's grievance policy. 2. During an observation of the facility, on 3/29/2023 from 9:15 A.M. - 9:30 A.M., there were Resident Rights posters on the walls in the resident lounge area of every unit, but no specific information regarding the facility's grievance officer's contact information and no grievance forms available. During an interview with CNA 6, on 3/29/2023 at 9:17 A.M., she indicated there were probably grievance forms locked up in a drawer at the nurse's stations. CNA 6 indicated there were also "Suggestion Boxes" on the walls on every unit, but Grievance forms were probably not to be placed in the boxes. During an interview with LPN 18, on 3/29/2023 at 9:20 A.M., she indicated she thought the grievance forms could be accessed on line.	F 0585	The facility is alleged to be out of compliance by failing to ensure information on how to file a grievance was made available to residents, and contact information of the grievance official was posted prominently. In addition, 6 of 6 alert and oriented residents attending the Resident Council meeting did not know how to access a grievance form. (Residents 19, 44, 48, 49, 61, and 67). A. The six residents were educated on instructions for filing grievances. Contact information for the grievance official was posted in a prominent position in the facility. Grievance forms are posted in accessible areas for both residents and staff. B. Residents were interviewed during the resident council to determine if other residents were unaware of the grievance process. No other residents were identified C. All residents and families receive letters educating them on the grievance process and the location of the contact information of the grievance official. D. An audit will be completed by Social Services/designee for residents knowledge of the grievance process refusals three times a week for 4 weeks, twice a week for 4 weeks , weekly for 4 weeks and monthly thereafter until found to be in substantial	06/06/2023

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	During an interview with the SSD (Social Services Director) on 3/29/23 9:33 A.M., "Suggestion boxes" were attached to the wall on each nurse's station and at the front desk. There were forms on a shelf just below the boxes and residents could fill out the forms. The Suggestion boxes were affixed to the walls and resembled a mail box with a small slot at the top of the box. The SSD indicated the Director of Nursing was responsible for maintaining the Suggestion boxes and went through any submitted forms and would forward any grievance forms to her. Because she was the Grievance officer, she indicated if there was a grievance placed in the suggestion box, either herself or the DON would assist the resident in filling out their concern on a Grievance form. The SSD agreed the only way an official grievance could be submitted was by asking a staff member for the form and/or asking a staff member to complete a form on the resident's behalf. Review of the current facility policy and procedure, titled, "Resident's Rights" provided by the Director of Nursing on 3/30/2023 at 8:50 A.M., included the following: "...g. Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community...9. The resident has the right to: a. Voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal...." 3.1-7(b)		compliance. Results will be reviewed by QAA and results reported in QAP	

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F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other			

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	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. Based on observation, interview and record review, the facility failed to develop and implement a personalized care plan for 2 of 24 residents whose care plans were reviewed. (Resident 8, 65) Findings include: 1. The record review for Resident 8 was reviewed on 3/29/2023 at 3:16 P.M. Diagnoses included, but were not limited to: anoxic brain damage, pulmonary emphysema and type 2 diabetes. During an observation, on 3/38/2023 at 12:15 P.M., there was a dressing dated 3/28/23 to Resident 8's right elbow. During an observation, on 3/29/2023 at 2:36 P.M., there was a dressing dated 3/29/23 to the right elbow. A Physician Order, dated 3/29/2023, indicated to clean the skin tear to the right elbow and cover with xeroform and dry dressing daily. During an interview, on 3/30/2023 at 11:33 A.M., the Assistant Director of Nursing (ADON) indicated that there was no care plan for a skin tear to the right elbow and there should have been one.	F 0656	The facility is alleged to be out of compliance by failing to develop and implement a personalized care plan for 2 of 24 residents whose care plans were reviewed. (Resident 8, 65). A. Careplans for residents 8 and 65 were reviewed updated, and personalized. B. Careplans were reviewed for all other hospice residents. No other residents were affected. C. Nursing staff were educated by MDS on the personalization of care plans and care plan revisions. D. An audit will be completed by MDS/designee for residents for personalized care plans/care plan revisions refusals three times a week for 4 weeks, twice a week for 4 weeks , weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	06/06/2023

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	2. A record review for Resident 65 was completed on 3/29/2023 at 8:57 A.M. Diagnoses included, but were not limited to: Alzheimer's disease, atrial fibrillation, and diabetes mellitus type 2. A Significant Change Minimum Data Set (MDS) Assessment, dated 2/13/2023, indicated Resident 65 used oxygen and was on hospice care. On 3/10/2023, a Physician's Order indicated for Resident 65 to have oxygen at two liters via nasal cannula to keep oxygen saturations above ninety-one percent. A care plan was not developed for respiratory issues or oxygen use. During an interview on 4/4/2023 at 9:06 A.M., the MDS Coordinator indicated that Resident 65 did not have a care plan for oxygen use. She indicated a care should be in place, and she would place a care plan for oxygen use. On 3/30/2023, at 1:35 P.M., the Director of Nursing provided a policy titled, "Comprehensive Care Plans", dated 10/2019, and indicated the policy was the one currently used by the facility. The policy indicated "...6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed...." This Federal tag relates to complaint IN00402235. 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 to update the plan of care for 4 of 17 residents reviewed for care planning. (Resident 8, 9, 65, D). Findings include: 1. The record for Resident 8 was reviewed on 3/29/2023 at 3:16 P.M. Diagnoses included, but	F 0657	The facility i alleged to be out of compliance by failing to update the plan of care for 4 of 17 residents reviewed for care planning. (Resident 8, 9, 65, D). A. Careplans for residents 8,9,65 and D were updated. B. Careplans were reviewed for all other residents who were on	06/06/2023

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	were not limited to: anoxic brain damage, pulmonary emphysema and type 2 diabetes. A Quarterly Minimum Data Set (MDS) Assessment, dated 2/9/2023, indicated Resident 8 had one stage 2 and two stage 1 pressure ulcers. A Care Plan, dated 10/31/2022, indicated Resident 8 had a Kennedy ulcer to her coccyx and 2 unstageable pressure ulcers to her right foot. During an observation of wound care and skin inspection with the Wound Nurse, on 3/30/2023 at 10:25 A.M., no Kennedy ulcer was observed on the coccyx and the skin was intact with no discoloration. One unstageable ulcer was observed to the right inner heel. During an interview, on 3/30/3023 at 11:35 A.M., the Assistant Director of Nursing (ADON) indicated that the care plan should have been revised since the Kennedy ulcer and one of the unstageable ulcers to the right heel was resolved. 2. The record for Resident 9 was reviewed on 3/30/2023 at 8:30 A.M. Diagnoses included, but were not limited to: history of falling, fracture of right radial closed fracture, and low back pain. A Progress Note, dated 12/16/2022 at 3:58 P. M., indicated the resident got up from her chair and walked to her doorway and fell. A Progress Note, dated 2/15/2023 at 10:50 A.M., indicated the resident fell trying to get into her bed and the wheelchair was not locked. A Progress Note, dated 3/11/2023 at 2:14 P.M., indicated the resident was sitting on the floor next to the bed.		hospice, had falls, had preventive equipment, or had edema for individualized care. No other residents were affected C. Nursing staff were educated by MDS on the personalization of care plans and care plan revisions. D. An audit will be completed by MDS/designee for residents for personalized care plans/care plan revisions refusals three times a week for 4 weeks, twice a week for 4 weeks , weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	

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	During an interview, on 3/30/2023 at 9:31 A.M., the Director of Nursing indicated that they were supposed to have an intervention put into place after every fall and she did not see one for 12/26/2022, 2/15/2023 and 3/11/2023. 3. The record for Resident D was reviewed on 3/29/2023 at 10:05 A.M. Diagnoses included, but were not limited to : edema, dementia without behavior disturbances, history of bariatric surgery. A Physician Order, dated 12/15/2022, indicated medigrips were to be placed on bilateral legs every day by night shift for edema. During an interview, on 3/30/2023 at 2:05 P.M., the ADON indicated she did not see medigrips added to the care plan and should have been. 4. During an observation on 3/27/2023 at 9:45 A.M. and 2:05 P.M., Resident 65 was observed lying in bed with no music or television playing in the room. On 3/28/23 at 8:44 A.M., Resident 65 was observed in bed sleeping. A record review was completed on 3/29/2023 at 8:57 A.M. Diagnoses included, but were not limited to: Alzheimer's disease, atrial fibrillation, and diabetes mellitus type 2. A Significant Change Minimum Data Set (MDS) Assessment, dated 2/13/2023, indicated Resident 65 had severe cognitive impairment, it was somewhat important to have books and magazines, to participate in religious activities, to do things with groups of people and to do			

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	favorite activities. It was very important to be around animals, and to go out for fresh air. An Activities Care Plan initiated on 2/7/2023, indicated Resident 65 needed reminders and escorts. The goal was for Resident 65 to attend activities of choice and participate in activities. The goals included to invite/remind for group activites, escort to /from groups, provide groups of interest including music, chirch, and to provide reading materials, puzzle books, and other supplies for independent activities, and to assist with television, phone, radio, and talking books as needed. During an interview on 3/31/2023 at 10:24 A.M., the Activity Director indicated that one-on-one visits were being completed., the care plan had not been updated when the comprehensive assessment of a significant change was completed. The Activity Director indicated Resident 65 should have an activity in her room. On 3/20/2023 at 1:35 p.m., the Director of Nursing provided a policy titled, " Care Plan Revisions", dated 10/2019, and indicated the policy was the one currently being used by the facility. The policy indicated "...1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change...." 3.1-35(e)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their			

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	choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to provide meaningful, personalized activities for 1 of 2 residents reviewed for activities. (Resident 65) Finding includes: During an observation on 3/27/2023 at 9:45 A.M. and 2:05 P.M., Resident 65 was observed lying in bed with no music or television playing in the room. During an observation on 3/28/2023 at 8:44 A.M., Resident 65 was in bed sleeping. During an observation on 3/29/2023 at 9:05 A.M., Resident 65 was in bed with no music or television on in the room. During an observation on 3/30/2023 at 10:14 A.M. and 2:38 P.M., Resident 65 was in bed with no music or television on in the room. A record review was completed on 3/29/2023 at 8:57 A.M. Diagnoses included, but were not limited to: Alzheimer's disease, atrial fibrillation, and diabetes mellitus type 2. A Significant Change Minimum Data Set (MDS) Assessment on 2/13/2023, indicated Resident 65 had severe cognitive impairment. The assessment indicated it was somewhat important to have books and magazines, to participate in religious	F 0679	The facility is alleged to be out of compliance by failing to provide meaningful, personalized activities for 1 of 2 residents reviewed for activities. (Resident 65). A. Personalized activities were provided, and care planned for resident #65. Resident #65 was reassessed for activities and preferences. The care plan was updated to reflect the current status. A radio/CD player was added to the room, and playing music. Rummage supplies were added to the resident's purse, and the resident was added to the list for 1-1 visits B. Residents were reviewed for activity preferences. Attendance logs were reviewed for possible candidates for 1-1 program. No other residents were affected C. Activities staff were educated by the Activities Director regarding personalized activities for all residents, 1-1 documentation and visits. AD to audit attendance logs monthly to observe for changes in residents' preferences and attendance D. An audit will be completed by Activities/designee for residents for personalized care plans/care	06/06/2023

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	activities, to do things with groups of people and to do favorite activities. It was very important to be around animals, and to go out for fresh air. An Activities Care Plan, initiated on 2/7/2023, indicted Resident 65 needed reminders and escorts. The goal was for Resident 65 to attend activities of choice and participate in activities. The goals included to invite/remind for group activities, escort to/from groups, provide groups of interest including music, church, and to provide reading materials, puzzle books, and other supplies for independent activities, and to assist with television, phone, radio, and talking books as needed. During an interview on 3/31/2023 at 10:24 A.M., the Activity Director indicated that staff were being educated regarding providing of one-on-one visits. The Activity Director indicated Resident 65 should have an activity in her room. On 4/3/2023 at 3:37 P.M., the Director of Nursing provide the policy titled, "Activities". The Policy indicated, " ...It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences of each resident. Facility-sponsored group and individual activities and independent activities will be designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident, as well as, encourage both independence and interaction within the community ...9. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs. These include, but are not limited to, considerations for: e. Residents who have		plan revisions refusals three times a week for 4 weeks, twice a week for 4 weeks , weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	

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	withdrawn from previous activities interest/customary routines, and isolates self in room/bed most of the day ...." 3.1-33(b)(8)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive 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 transcribe orders timely, obtain an order for a completed treatment and document new skin issues. (Resident 41, 7, 8) Findings include: 1. A record review for Resident 41 was completed on 3/29/2023 at 1:30 P.M. Diagnoses included, but were not limited to: hemiplegia cerebral infarction right side, aphasia, and quadriplegia. An Annual Minimum Data Set (MDS) Assessment, dated 2/22/2023, indicated he was total dependent for bed mobility, transfers, toileting and personal hygiene with assist of 2 staff members. During an observation, on 3/27/2023, at 12:42 P.M., Resident 41 was up in a Broda chair, he had a carrot in his left hand, and splints to his	F 0684	The facility is alleged to be out of compliance by failing to transcribe orders timely, obtain an order for a completed treatment and document new skin issues. (Resident 41, 7, 8) A. Residents were assessed and found to have no issues from untimely order transcription. MD was notified of the untimely transcription and new orders obtained for resident $41. Treatment orders for obtained for resident # 8 and new skin issues for resident #8 were documented and MD notified. B. An audit of treatment orders for the last 30 days was completed to ensure no other orders were transcribed untimely. Residents were assessed and no new skin issues were identified. No other	06/06/2023

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	feet/ankles only. During an observation, on 3/28 2023, at 9:11 A.M., the resident was in bed had no hand splints, prevalon boots or any leg devices in place and his heels were not floated. During an observation, on 3/28/2023 at 2:23 P.M., the resident was sitting in his room in a Broda chair. He had bilateral soft hand splints in place and abductor/adductor leg strap and splints to his foot/ankles. During an observation, on 3/28/2023 at 3:58 P.M., the resident was in bed with no splints and with socks on his feet, his heels were not floated. During an observation, on 3/29/2023 AT 9:05 A.M., the resident was in bed, his heels were not floated and prevalon boots were not in place. During an observation, on 3/29/2023 at 1:18 P.M., the resident was seated in the common area in his Broda chair with a Kennedy collar, ankle splints, hand splints, right arm elbow orthosis and abductor/adductor leg strap in place. During an observation, on 3/30/2023 at 8:53 A. M., the resident was in bed awake, barefoot, and his heels were not floated. There were no splints in place. During an observation, on 3/31/2023 at 8:40 A. M., the resident was in bed and did not have prevalon boots and splints in place. In addition, his heels floated were not floated. A Physician order, dated 8/19/2019, indicated prevalon boots were to be on at all times.		residents were affected. C. Nursing staff were educated by the DON on physician orders and changes in condition. D. An audit will be completed by the DON/designee for timely physician order transcription, treatment orders and changes of condition refusals three times a week for 4 weeks, twice a week for 4 weeks , weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	

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	A Physician Order, dated 12/22/2019, indicated left prafo boot and right elbow orthosis was to be worn every shift. A Physician Order, dated 7/13 2020, indicated the residents heels were to be floated while he was in bed. A Physician Order, dated 4/20/2022, indicated the resident was to be encouraged to use a "carrot" (soft contracture prevetative device) to bilateral hands every shift. A Physician Order, dated 10/28/2019, indicated the resident to wear a Kennedy collar 3 times a day when up in chair. During an interview, on 3/30/2023 at 11:54 A. M., CNA 2 indicated that the resident wore big fluffy green boots but was not wearing them today and sometimes he wore carrots in his hands. The therapist had completed education a couple of weeks ago on what devices to put on Resident 41. The therapist had instructed staff to put on soft hand splints, abductor/adductor leg strap and feet/ankle splints. During an interview, on 3/30/2023 at 2:25 P.M., the ADON indicated that he has an order for prevalon boots and prafo boots at all times and indicated the order needed to be clarified because he cannot wear both at the same time. She located the prevalon boots on top of the free standing closet. She could not locate an order for the abductor/adductor leg strap and or hand splints and the elbow orthosis should have been on him and it was not. During an interview, on 3/30/2023 at 2:30 P.M., with Occupational Therapist 15 via phone she			

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	indicated she wrote new orders on 3/27/2023 and placed in the order book for the new devices. During an interview, on 3/30/2023 at 3:52 P.M., the ADON located the order and indicated the orders should have been transcribed and he should be wearing the correct devices. The Physician Telephone Order, dated 3/27/202, indicated the resident splint wearing recommendations were: "... Kentucky collar neck/headbrace on when up in wheelchair and out of bed; off when back to bed, right elbow brace and bilateral hands splints on at 11:00 A.M. off at 9:00 P.M., abductor/adductor leg strap on at 11:00 A.M., and off at 9:00 P.M. Bilateral foot and ankle support on at 11:00 A.M., and off at 9:00 P. M...." 2. The record for Resident 7 was reviewed on 3/30/2023 at 10:00 A.M. Diagnoses included, but were not limited to: dementia with behavioral disturbances, anxiety disorder, and major depressive disorder. An Annual MDS, dated 1/25/2023, indicated she required extensive staff assistance with bed mobility, transfers, wheelchair locomotion, dressing, hygiene, and toileting. During an observation, on 3/27/2023 at 2:17 P.M., the right wrist/forearm were light purple . During an observation, on 3/31/2023 at 9:04 A.M., the left arm extending from the wrist to below the elbow was dark purple. A Shower Sheet, dated 3/17/2023 and 3/24/2023, indicated no skin issues. During an interview, on 3/31/2023 at 9:58 A.M.,			

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	the Assistant Director of Nursing (ADON) indicated the nurse did a skin check on 3/27/2023 at 11:09 P.M. and did not document any bruise to the left arm. During an observation and interview on 3/31/2023 at 9:15 A.M. the bruising of Resident 7 was brought to the Director of Nursing's attention. During an interview, on 3/31/2023 at 12:00 P.M., the Director of Nursing (DON) indicated the resident went out over the weekend to the emergency room for behaviors and she was there for 19 hours. The hospital records documented the bruise to the left arm. When she returned, she would have expected the nurse to do a head to toe assessment of her body and document any skin issues in the progress notes and fill out a skin sheet but she did not. 3. The record for Resident 8 was reviewed on 3/29/2023 at 3:16 P.M. Diagnoses included, but were not limited to: anoxic brain damage, pulmonary emphysema and type 2 diabetes. During an observation, on 3/28/2023 at 9:23 A.M., a dressing on her right arm dated 3/28 was in place. During an observation, on 3/29/2023 at 2:36 P.M., a dressing on her right arm dated 3/29 was in place. A Physician's Order, dated 3/29/2023, indicated to clean the skin tear with wound cleanser and cover with a xeroform and dry dressing daily. During an interview, on 3/30/2023 at 11:18 A.M., the ADON indicated if a new skin injury was noted she would expect the nurses to fill out an			

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	incident report, notify the doctor and the family, determine the cause, document in the progress notes, and inform management. She could not find the documentation in the progress notes of the skin injury, incident report, and notification to doctor or family and it should have been completed. On 3/30/2023 at 2:00 P.M., the ADON provided a policy titled, "Skin Integrity-Skin Tears", dated 3/30/2023, and included the policy was the one currently used by the facility. The policy indicated "...c. When a skin tear is discovered, the nurse shall complete an incident report. The following information shall be recorded: iii. The site and description of the skin tear, ix. The date and time the physician and resident representative were notified, and x. Any other information relevant to the incident...." On 3/31/2023 at 11:02 A.M., the ADON provided a policy titled, "medication Orders Policy", revised 5/20/2022, and included the policy was the one currently used by the facility. The policy indicated "...5. Specific Procedures for Medication Orders: a. Handwritten Order Signed by the Physician- The charge nurse on duty at the time the order is received should note the order and enter it on the physician order sheet or electronic order format, if not written by the physician...." On 3/31/2023 at 11:02 A.M., the ADON provided a policy titled "Residents Rights Regarding Treatment and Advanced Directives", dated 3/1/2023, and included the policy was the one currently used by the facility. The policy indicated "...11. Should the resident refuse treatment of any kind, the facility will document			

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	the following in the resident's chart: a. What the resident refused. b. The reason for the refusal. f. That the physician was notified of refusal and the resident's response to education/offering of alternatives...." On 3/31/2023 at 12:01 P.M., the ADON provided a policy titled, "Call Lights", dated 10/1/2019, and indicated the policy was the one currently used by the facility. The policy indicated "...5. With each interaction in the resident's room or bathrooms, staff will ensure the call light is within reach of resident and secured, as needed....." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to prevent an open area for 1 out of 4 residents reviewed for pressure ulcer/injury. (Resident 8) Finding Includes:	F 0686	The facility is alleged to be out of compliance by failing to prevent an open area for 1 out of 4 residents reviewed for pressure ulcer/injury. (Resident 8) A. Resident #8 no longer residents	06/06/2023

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	The record for Resident 8 was reviewed on 3/29/2023 at 3:16 P.M. Diagnoses included, but were not limited to: anoxic brain damage, pulmonary emphysema and type 2 diabetes. A Quarterly Minimum Data Set (MDS) Assessment, dated 2/9/2023, indicated she was extensive assist of 2 staff for bed mobility, transfers, toileting, and personal hygiene and was at risk for pressure ulcer development. A Physician Order, dated 2/21/2023, indicated for the nurse to verify prevalon boots are on bilateral feet to off load pressure every shift. During an observation of a dressing change on 3/30/2023 at 10:44 A.M., the Wound Nurse lifted the sheet, the prevalon boots were twisted off the heels with the straps across the top of the foot/ankle. Two open areas were noted to the left anterior ankle distal measured 2.1 x 2.4 cm (centimeter) x 0.1 cm, and left anterior ankle proximal 0.5 x 1.5 x < 0.1 cm. The Wound Nurse indicated that it was caused by the strap due to the boots not being on correctly. On 3/30/2023 at 2:00 P.M., the Assistant Director of Nursing (ADON) Provided a policy titled, Pressure Injury Prevention and Management", revised 10/24/2022, and indicated the policy was the one currently used by the facility. The policy indicated, "...5. Monitoring d. The effectiveness of current preventative and treatment modalities and processes will be discussed in accordance with the QAA Committee Schedule, and as needed when actual or potential problems are identified...." 3.1-40(a)(1)		in the facility. B. Other residents who wear prevalon boots were assessed and no new open areas identified. C. Nursing staff were educated by the DON on wound prevention and notification of changes. D. An audit will be completed by the DON/designee for new open areas refusals three times a week for 4 weeks, twice a week for 4 weeks , weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure an intervention was implemented after a fall for 1 of 3 residents reviewed for accidents. (Resident 9) Finding includes: 1. The record for Resident 9 was reviewed on 3/30/2023 at 8:30 A.M. Diagnoses included, but were not limited to: history of falling, fracture of right radial closed fracture, and low back pain. A Significant Change, Minimum Data Set (MDS) Assessment, dated 12/20/2022, indicated the resident had a major injury from a fall. A Progress Note, dated 12/16/2022, indicated she got up out of the wheelchair and walked towards her room and fell, breaking her fall with her right hand. She complained of pain to the right wrist and an x-ray was ordered. She had a fracture of the right distal radius. A Care Plan for falls, dated 9/13/2022, indicated an intervention for the 12/16/2022 fall was to obtain an x-ray of the right wrist and notify the doctor of the results.	F 0689	The facility is alleged to be out of compliance by failing to ensure an intervention was implemented after a fall for 1 of 3 residents reviewed for accidents. (Resident 9) A. The fall for resident #9 was reviewed and an intervention identified and care planned. B. Care plans for residents with falls within the last audited for fall interventions. No other residents identified without fall interventions C. Nursing staff was educated by the DON regarding fall interventions. D. An audit will be completed by the DON/designee for fall interventions refusals three times a week for 4 weeks, twice a week for 4 weeks , weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	06/06/2023

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	During an interview, on 3/30/2023 at 9:31 A.M., the Director of Nursing indicated that they review the falls in the morning clinical meeting and update the care plan, there was not an intervention put into place for fall prevention for the fall on 12/16/2022, and there should have been. On 3/30/2023 at 10:12 A.M., the Director of Nursing provided a policy titled, "Fall Prevention Program Policy", dated 4/9/2019, and indicated the policy was the one currently used by the facility. The policy indicated "...9. When any resident experiences a fall, the facility will: e. Review the resident's care plan and update as indicated....." 3.1-45(a)(2)			
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 access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs			

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	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, record review and interview, the facility failed to ensure over the counter medications were accurately labeled for 3 of 3 medication rooms observed and 2 of 3 medication carts observed. (East, Center and Grove unit medication rooms and East and Grove unit medicaiton carts) Findings include: During an observation of medication rooms and medication carts, conducted on 3/29/2023 at 10:09 A.M., the following was noted: 1. The Center unit medication room had a bottle of over- the- counter probiotic capsules with the date opened and the resident's name handwritten on the bottle. There was no physician's name and/or dose ordered written on the bottle. In addition, in the refrigerator, there was a bottle of liquid medication, labeled Omega D with only the resident's name written on the top of the bottle cap. During an interview RN 12 indicated only the resident's name and date opened had been written on the medications. 2. The East unit medication room had two partially used tubes of arthritic cream. There was no name or label on the medicated cream. 3. The East unit medication cart, observed with LPN 22 had one unopened, unlabeled bottle of Omega Red supplement. LPN 25 indicated he was	F 0761	The facility is alleged to be out of compliance by failing to ensure over the counter medications were accurately labeled for 3 of 3 medication rooms observed and 2 of 3 medication carts observed. (East, Center and Grove unit medication rooms and East and Grove unit medicaiton carts) A. Medication rooms and medication carts were audited for OTC medications. OTC medications were labeled accurately. B. The remaining medication cart was audited and no other OTC medications were identified to be unlabeled. C. Nursing staff were educated by the DON on Labeling of Medications. D. An audit will be completed by the DON/designee of medication rooms and medication carts for appropriately labeled OTC medications. Audits will be completed refusals three times a week for 4 weeks, twice a week for 4 weeks , weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	06/06/2023

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	removing the bottle of medication as it was not labeled. 4. The medication cart on the Grove nursing unit had an opened albuterol inhaler without the label on it. RN 23 indicated it belonged to Resident 226. RN 23 indicated the inhalers were usually stored in the labeled box and the date the inhaler was opened should have been written on the inhaler itself. 5. The medication room, on the Grove nursing unit had an over the counter bottle of Zinc and Vitamin D. Both bottles were unlabeled. RN 23 indicated the medication was Resident 227 and she removed the bottles and gave them to the resident's husband to take home. Review of the facility policy and procedure, titled, "Labeling of Medications and Biologicals" provided by the Director of Nursing on 3/30/2023 at 8:30 A.M. included the following instructions: "...4. Labels for individual drug containers must include: a. The resident's name; b. The prescribing physician's name; c. The medication name; d. The prescribed dose, strength, and quantity of the medication; e. The prescription number; f. The date the drug was dispensed...i. The route of administration... 7. Labels for over -the -counter (OTC) medications must include: a. The original manufacturer's or pharmacy applied label indicating the medication name; b. The strength, quantity, lot, and control number; c. The expiration date when applicable; d. Appropriate accessory and precautionary statements; e. Direction s for use...9. Labels for medication designed for multiple administrations (such as inhalers..., the label will identify the specific resident for whom it was prescribed...."			

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	3.1-25(j)			
F 0804 SS=F Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review and interview, the facility failed to ensure the cook followed the recipes for pureed chicken. This deficient practice had the potential to affect 6 of 6 residents who required pureed food. (Cook 24) Finding includes: During an observation of the pureed food process, conducted on 3/28/23 at 9:29 A.M., Cook 24 placed 10 - 4 ounce scoops of diced cooked chicken into the food processor and added approximately 2 cups of water. After pureeing the mixture, she added two additional cups of water. Review of the recipe for pureed chicken indicated the chicken was to be pureed with chicken broth. During an interview with Cook 24 on 3/28/2023 at 9:40 A.M., she indicated the diced chicken had just been cooked in plain water and she had not added any flavoring nor followed the recipe using broth. Review of the facility policy and procedure, titled,	F 0804	The facility is alleged to be out of compliance by failing to ensure the cook followed the recipes for pureed chicken. This deficient practice had the potential to affect 6 of 6 residents who required pureed food. (Cook 24) A. Cook 24 was educated regarding pureed recipes. B. All residents on pureed diets have the potential to be affected. C. Cooks were educated by the RD on pureed diets D. An audit will be completed by the Dietary Manager/designee regarding following pureed diets. Audits will be completed for refusals three times a week for 4 weeks, twice a week for 4 weeks , weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and reported in QAPI.	06/06/2023

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	"Puree Food Prep Policy" provided by the Director of Nursing on 3/30/2023 at 8:30 A.M., indicated: "... It is the policy of this facility to provide puree food that has been prepared in a manner to conserve nutritive value, palatable flavor, and attractive appearance...5. Do not use water as an additive to prepare puree foods. Refer to your department's Dietary Services manual for additional policy and procedures...7. Puree Food Preparation Guidelines per Serving: (More or less may be used depending on the consistency of the cooked food): ...Poultry: Add 1 teaspoon chicken broth or chicken gravy...." 3.1-21(a)(1)			
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, record review and interview, the facility failed to ensure food was stored in accordance with professional standards for food safety for 1 of 1 kitchens. This deficient practice had the potential to affect 74 of 74 residents who received food from the kitchen. (Main Kitchen) Findings include: 1. During a tour of the kitchen, conducted on 3/27/23 at 9:44 A.M., with the senior FSS (Food Service Supervisor), the following was observed: There were 4 cases of unpasteurized eggs in the walk in refrigerator. The FSS indicated the eggs were supposed to be pasteurized and were ordered in error as the facility did serve fried eggs to residents.-The FSS immediately discarded the unpasteurized eggs and no under cooked, unpasteurized egg was observed being served during the survey process. During a review of Infection Surveillance, completed with the ADON, on 3/29/2023 at 11:00 A.M., there were no gastrointestinal outbreaks noted in the past year. One of two drainage pipes, located underneath an ice machine,was touching the side of the floor drain and no air gap was observed. 2. During an observation of the pureeing process for the noon meal food items, conducted on 3/28/2023 at 9:29 A.M., Cook 24 was noted to puree chicken in the food processor. After finishing the chicken and placing the pureed chicken into a steam table pan, Cook 20 took the dirty food processor and rinsed it out at a sink and then put the rinsed food processor and	F 0812	The facility is alleged to be out of compliance by failing to ensure food was stored in accordance with professional standards for food safety for 1 of 1 kitchens. The facility had unpasteurized eggs stored in the refrigerator. This deficient practice had the potential to affect 74 of 74 residents who received food from the kitchen. (Main Kitchen) A. Non pasturized eggs were discarded. Dietary Manager was educated by the Administrator to ensure pasturized eggs are ordered and utilized. B. Kitchen was audited for items not stored according to professional standards. No other items were identified. C. Kitchen staff were educated by the Dietary Manager regarding the use of pasteurized eggs. D. An audit will be completed by the Dietary Manager/designee to ensure items are stored according to professional standards three times a week for 4 weeks, twice a week for 4 weeks , weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and reported in QAPI.	06/06/2023

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	attachments into a tray and ran the tray through the dishwasher. Without washing her hands, she then retrieved the food processor, blade attachment and plastic lid and lid stopper, carried them back to the food processor motor and proceeded to puree carrots. The cook used her bare hands to adjust the blade onto the food processor motor. During an observation of the puree process, another dietary employee was observed, with gloved hands, grabbing handfuls of sliced and chunked ham and putting the meat into a large stand mixer. The dietary employee was noted to touch foil lids, outsides of pans and the stand mixer with her gloved hands and then without changing her gloves, continued grabbing handfuls of meat. The FSS indicated the cook was preparing ham loaf. The current facility policy, titled, "Dietary Employee Personal Hygiene Policy, provided by the Director of Nursing on 3/30/2023 at 8:30 A.M. included the following instructions: "... 3. Hands and Fingernails...b. g. Gloves are to be worn and changed appropriately to reduce the spread of infection." There were no specific instructions regarding when to change gloves and no instructions to wash hands after handling dirty items before coming in contact with clean kitchen utensils...." The current facility policy, titled, "Safe Handling of Eggs" included the following instructions: "...1. Pasteurized shell eggs or liquid pasteurized eggs will be utilized for all products requiring eggs as an ingredient...7. For all other forms of egg preparation, including hot holding of eggs, and pooling the eggs must be pasteurized...."			

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	The policy regarding air gaps for ice machine drainage pipes was requested on 3/29/2023 at 2:00 P.M. and there was no policy submitted for review prior to the survey exit. 3.1-21(i)(3)			
F 9999 Bldg. 00	State Rules 3.1-14 PERSONNEL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. (k) There shall be an organized, ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to the following: (1) Resident Rights This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 5 new employee files reviewed contained documentation the references had been checked (Employee 3) and 2 of 5 employees with hire dates greater than 1 year prior had resident rights inservice documentation. (1 and 2) Findings include:	F 9999	The facility is alleged to be out of compliance by to ensure 1 of 5 new employee files reviewed contained documentation the references had been checked (Employee 3) and 2 of 5 employees with hire dates greater than 1 year prior had resident rights inservice documentation. (1 and 2) A. References were obtained for 1 employee. Employees numbers 1 and 2 received resident rights training. B. Employee files were audited for reference checks and resident rights training C. Human Resources was educated by the Administrator regarding employee files. System review and change to request reference checks be completed by system's hiring agency of International Nurses prior to the hiring. The agency has been notified and educated. D. An audit will be completed by Human Resources three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks	06/06/2023

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	1. During review of the personnel files, the file for Employee 3, a nurse with a start work date of 6/6/2022 was reviewed. There was no documentation of any reference inquiry. During an interview with the Business Office Manager, on 3/30/2022 at 11:00 A.M., she indicated Employee 3 was an international nurse and the facility utilized an out of state company and there was no way for the facility to check any references. The Business Office Manager indicated the out of state company was responsible to ensure the credentialing and licensure was in order. The current facility policy, titled, "References Checks", provided by the Business Office Manager on 3/30/2023 at 11:00 A.M., included the following procedure: "...Candidates will provide Hamilton Grove with a list of references. The HR leader, department leader or designee will Contac the individuals and/or business the candidate has provided to seek input on the candidate. The desire is to obtain two references on newly hired team members...." 2. During review of the personnel files, the file for Employee 1, a nurse with a start work date of 12/5/2017, there was no documentation the employee had completed an inservice regarding resident rights in the past 12 months. During review of the personnel file for Employee 2, a nursing assistant with a start work date of 12/9/2015, there was no documentation the employee had completed an inservice regarding resident rights in the past 12 months. During an interview with the Business Office Manager, on 3/30/2023 at 10:45 A.M., she		and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and reported in QAPI.	

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	indicated the facility utilized an electronic routine inservice system once employees were hired and had completed the initial orientation process. She indicated she reviewed the inservice completions for employees and sent notes to alert them when there were overdue required inservices that needed completed but employees were not always responsible to complete the annually required inservices, which included Resident Rights. The current policy regarding Resident Rights, provided by the Director of Nursing on 3/30/2023 at 8:30 A.M. indicated employees and contrasted employees would be inserviced on resident rights but there was no specific frequency noted in the policy.			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Annual Recertification and Licensure Survey and the Investigation of Complaint IN00402235. Survey dates: April 3 and 4, 2023 Facility number: 000427 Residential Census: 44 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 4/20/2023.	R 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
R 0026 Bldg. 00	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The			

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	licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on observation and interview, the facility failed to post a copy of the Resident's Rights available in a publicly accessible area. This has the potential to affect 44 residents residing in the facility. Finding includes: During an interview on 4/3/2023 at 1:50 P.M., the Assisted Living Supervisor indicated she could not locate the posting of the Residents Rights and it should have been posted in public view. On 4/3/2023 at 2:00 P. M., the Assisted Living Supervisor provided a policy titled, "Resident Rights", revised 10/24/2022, and indicated the policy was the one currently used by the facility. The policy indicated "... The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights	R 0026	The community was alleged to be out of compliance by failing to ensure the posting of Resident Rights in publicly accessible areas. This had the potential to affect 44 of 44 residents residing at the facility. A. Resident Rights were posted in publicly accessible areas. B. Housewide assessment completed to identify posting. C. Assisted living supervisor educated by Administrator regarding resident rights postings. D. An audit will be completed by Assisted Living Supervisor / designee three times a week for 4 weeks, twice a week for 4 weeks , weekly for 4 weeks and monthly thereafter until found to be in	06/06/2023

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	and all rules and regulations governing resident conduct and responsibilities during the stay in the facility...."		substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.			
	Based on interview and record review, the facility failed to ensure twelve fire drills were conducted the past year and a fire and disaster drill was conducted every six months in conjunction with the local fire department. This had the potential to affect 44 of 44 residents residing at the facilty. Finding includes:	R 0092	The community was alleged to be out of compliance by failing to ensure twelve fire drills were conducted the past year and a fire and disaster drill was conducted every six months in conjunction with the local fire department. This had the potential to affect 44	06/06/2023

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	On 4/3/2023 at 9:35 A.M., the Maintenance Director indicated that they did not do all the required fire drills and hold fire and disaster drills with the local fire department. On 4/3/2023 at 12:14 P.M., the Maintenance Director provided a policy titled, "Fire and Disaster Safety Plan", dated 4/3/2023 and indicated the policy was the one currently used by the facility. The policy indicated "...1. Fire drills will be conducted monthly on rotating shifts and be unannounced. All personnel present at the time of the drill are required to participate and sign in to signify their participation and understanding of the drill procedures. a. The facility will attempt to coordinate fire and disaster drills with local fire departments every six months...."		of 44 residents residing at the facility. A. Fire drill scheduled with local fire department. B. Fire drill logs audited C. Maintenance was educated by Administrator regarding fire drills. D. An audit will be completed by Maintenance designee three times a week for 4 weeks, twice a week for 4 weeks , weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to ensure reference inquiries were completed for 2 of 5 newly hired employees. (Employee 15 and 16) Findings include: 1. During a review of the personnel files for 5 newly hired employees, conducted on 3/29/2023 at 2:30 P.M., the following was observed:	R 0116	The community was alleged to be out of compliance by failing to ensure reference inquiries were completed for 2 of 5 newly hired employees. A. References were obtained for employees 15 and 16. B. Employee files were audited for reference checks. C. Human Resources educated by	06/06/2023

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	The personnel file for Employee 15, with a start work date of 2/11/2022, did not have any documentation of a reference inquiry. The personnel file for Employee 16, with a start work date of 8/16//2022, did not have any documentation of a reference inquiry. 2. During an interview with the Business Office Manager, on 3/30/2022 at 11:00 A.M., she indicated Employee 16 was an International nurse and the facility utilized an out of state company and there was no way for the facility to check any references. The Business Office Manager indicated the out of state company was responsible to ensure the credentialing and licensure was in order. There was no reason given why there was no reference documentation for Employee 15. The current facility policy, titled, "References Checks", provided by the Business Office Manager on 3/30/2023 at 11:00 A.M. included the following procedure: "...Candidates will provide Hamilton Grove with a list of references. The HR leader, department leader or designee will Contac the individuals and/or business the candidate has provided to seek input on the candidate. The desire is to obtain two references on newly hired team members...."		Administrator regarding employee files. D. An audit will be completed by Human Resources designee three times a week for 4 weeks, twice a week for 4 weeks , weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications,			

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	and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure staff met requirements regarding First Aid training certification of 1 certified staff per shift for 3 of 21 shifts reviewed. Finding includes: On 4/4/2023 at 9:00 A.M., a review of schedules for all three shifts, dated 3/27/2023 through 4/2/2023 indicated three shifts were not covered with personnel certified in CPR and First Aid. The shifts were as follows: 3/31/2023 11:00 P. M.- 7:00 A. M and 4/1/2023 11:00 P. M.- 7:00 A.M. and 4/2/2023 11:00 P. M.- 7:00 A. M. During an interview, on 4/4/2023 at 9:45 A.M., the Assisted Living Supervisor indicated she was not aware of the three shifts not covered by personnel with CPR and First Aide training. On 4/4/2023 at 10:01 A.M., the Assisted Living	R 0117	The community was alleged to be out of compliance by failing to ensure staff met requirements regarding First Aid training certification of 1 certified staff per shift for 3 of 21 shifts reviewed. A. All staff received first aid certification. B. Audit completed to ensure all staff obtained necessary first aid certifications. C. Human Resources educated by Administrator regarding employee files. D. An audit will be completed by Human Resources designee three times a week for 4 weeks, twice a week for 4 weeks , weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be	06/06/2023

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	Supervisor provided a policy titled, "CPR Policy (AL)", and indicated it was the policy currently used by the facility. The policy indicated "...CPR and First Aid certified staff will be available at all times...."		reviewed by QAA and results reported in QAPI.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor.			

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	(C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure 2 of 5 assisted living employees with hire dates greater than one year had been annually inserviced regarding resident rights. (Employee 13 and 14) Findings include: During review of personnel files, conducted on 3/29/2023 at 2:30 P.M., the following was observed: 1. The personnel file for Employee 13, with a start work date of 7/7/2020, had no documentation an inservice regarding resident rights had been completed in the most recent calandar year. 2. The personnel file for Employee 14, with a start work date of 1/25/2016, had no documentation an inservice regarding resident rights had been completed in the most recent calendar year. 3. During an interview with the Business Office Manager, on 3/30/2023 at 10:45 A.M., she indicated the facility utilized an electronic routine inservice system once employees were hired and had completed the initial orientation process. She indicated she reviewed the inservice completions for employees and sent notes to alert them when there were overdue required inservices that needed completed but employees were not always responsible to complete the annually required inservices, which included Resident Rights. The current policy regarding Resident Rights,	R 0120	The community was alleged to be out of compliance by failing to ensure 2 of 5 assisted living employees with hire dates greater than one year had been annually in-serviced regarding resident rights. A. Employees 13 and 14 completed Resident Rights in-service. B. Employee files audited for Resident Rights training. C. Human Resources educated by Administrator regarding employee files. D. An audit will be completed by Human Resources designee three times a week for 4 weeks, twice a week for 4 weeks , weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	06/06/2023

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	provided by the Director of Nursing on 3/30/2023 at 8:30 A.M., indicated employees and contracted employees would be inserviced on resident rights but there was no specific frequency noted in the policy.			