STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155858	A. BUILDING 00 B. WING	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF WHITESTOWN, THE	6712 RESTORACY DRIVE WHITESTOWN, IN 46075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 1, 2, 3, 4, and 5, 2022. Facility number: 014586 Provider number: 155858 AIM number: 300040744 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicare: 9 Medicaid: 34 Other: 25 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 18, 2022.	F 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed			

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

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	medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			
	Based on observation, interview, and record review, the facility failed to ensure an advanced directive was charted according to the resident's preference for 1 of 16 residents reviewed for advanced directives (Resident 39). Findings include:	F 0578	The Restoracy of Whitestown Plan of Correction- F578 **Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an	09/12/2022

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	On 8/2/22 at 12:51 p.m., Resident 39's record was reviewed. He was admitted on 10/19/21. His diagnoses included, but not limited to pericardial effusion (increased fluid around the heart), cerebral infarction (stroke), and acute kidney failure. Resident 39's code care plan, dated 10/22/21, indicated his preference was Do Not Resuscitate (DNR). Resident 39's Physician Orders for Scope of Treatment (POST) form, dated 10/26/21, indicated do not attempt resuscitation/DNR. It was signed by the resident and his POA (Power of Attorney). Resident 39's physician code order, dated 6/4/22, indicated his advanced directive was a full code. On 8/2/22, Resident 39's physician's code order was changed to DNR. During an interview, on 8/2/22 at 2:55 p.m., the Director of Nursing (DON) reviewed the physician's order and indicated Resident 39's code order was a full code. Her expectation was for the nursing staff was to recognize the inconsistencies in the physician order and the code care plan and bring that information to herself and the social services director to correct it. A current policy, titled, "Advance Directives," with no date, was provided by the Social Services Director (SSD) on 8/3/22 at 3:38 p.m. A review of the policy indicated, " ...The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive ...." 3.1-4(f)(4)(A)(ii)		admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure advanced directives are charted according to the resident preference. **Corrective Action for resident(s) found to have deficient:** Medical Director notified of advanced directive error made upon readmission to the facility on 8/2/22 for resident #39. Order corrected to reflect advance directive with no negative outcome, prior to survey exit. **Identify other residents having same potential deficient:** Resident's that have had a readmission to the facility have the potential to be affected by the alleged deficient practice. All current resident who had a readmission to the facility have been audited by the Social Service Director, ensuring all orders, careplans, and post forms represent the preferred advanced directive. No other residents were identified as affected. **Measures put into place or systemic changes:** The Assistant Director of Nursing or designee will	

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			provide education to the license nurses on the policy/procedures for obtaining and recording advanced directives on readmission, by the day of compliance. PRN nurses will receive education prior to their first scheduled shift. **Plan to monitor performance to maintain compliance:** Social Service Director or designee will audit advanced directives on all readmissions on the next business day for a minimum of 6 months until 100% of compliance is maintained. Audit will ensure orders, care plan, and post forms match and represent the resident's choice. If any compliance trends are identified, they will be reviewed in QAPI meetings **Date of Compliance: 9/12/22**	
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 observation, record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was coded correctly for 2 of 20 residents reviewed for MDS assessments (Residents 17 and 32). Findings include:	F 0641	The Restoracy of Whitestown Plan of Correction- F641 **Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this	09/12/2022

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	1. On 8/03/22 at 3:25 p.m., the medical record was reviewed for Resident 17. The diagnoses included but were not limited to bipolar disorder (a mental health disorder). On 8/1/22 the Director of Nursing (DON) provided a second facility resident matrix which indicated "Corrected" at the top right-hand corner. This matrix did not indicate Resident 17 had a Pre-admission Screening and Resident Review (PASARR) Level II assessment. A physician's order indicated: "Behavior Monitoring: Resident has a history of bipolar disorder. may have manic episodes. monitor for compulsiveness, and excessive euphoric behaviors. may be tearful at times. does occasionally refuse medications. document each incident in nursing note with interventions attempted and effectiveness." A review of the annual Minimum Data Set (MDS) assessment, dated 2/18/22, indicated Resident 17 did not have a PASAR Level II. A PASAR Level II, dated 3/10/21, was scanned into the medical record documents. It indicated a Level II was required but the resident did not require specialized services. On 8/3/22 at 10:16 a.m., during an interview, the MDS coordinator indicated Resident 17 did have a PASAR Level II in her medical record. Her last annual MDS assessment had been coded wrong. 2. On 8/03/22 at 12:37 p.m., the medical record was reviewed for Resident 32. The diagnoses included, but were not limited to, chronic pain. On 8/1/22 the Director of Nursing (DON) provided		Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure the MDS assessment was coded correctly for two residents. Resident #17 MDS assessment did not indicate that she required a level 2 service. Resident #32 MDS assessment did not indicate that resident was receiving hospice services. **Corrective Action for resident(s) found to have deficient:** MDS coordinator immediately submitted corrected MDS assessments to MDS for resident #17 and resident #32. MDS coordinator completed an audit the most recent MDS assessments for all residents receiving hospice services and level 2 services to ensure all assessments were coded correctly. No other deficiencies were identified. **Identify other residents having same potential deficient:** Residents receiving level 2 services and hospice services have the ability to have the alleged deficiency. **Measures put into place or**	

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	a second facility resident matrix which indicated "Corrected" at the top right-hand corner. The matrix did not indicate Resident 32 was on hospice services. A physician order, dated 7/30/20, indicated hospice. A review of the quarterly MDS assessment, dated 6/7/22, did not indicate Resident 32 was on hospice. On 8/3/22 at 10:16 a.m., during an interview, the MDS coordinator indicated Resident 32's MDS assessment was coded wrong. She had been on hospice since 2020. On 8/4/22 at 9:40 a.m., the DON provided a current policy, dated October 2019, titled, "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual." This policy indicated "...if an error is discovered in a record that has already been accepted by the QIES ASAP system, implement procedures for either modification or inactivation of the information in the system...." 3.1-31(c)(1)		**systemic changes:** MDS coordinator will complete a response analyzer when completing MDS to ensure level 2 services and hospice services are coded correctly. **Plan to monitor performance to maintain compliance**: Social Service Director or designee will audit MDS for residents receiving hospice services or in need of level 2 services to ensure questions 00100K or A1500 are coded correctly x 6 months. Any compliance trends identified will be addressed in QAPI. **Date of Compliance: 9/12/22**	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-			

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	(i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			
	Based on observations, interviews, and record review, the facility failed to ensure a resident who was hard of hearing (HOH) had a baseline care plan to address his specific needs for 1 of 1 residents reviewed for hearing and vision	F 0655	The Restoracy of Whitestown Plan of Correction- F655 **Disclaimer:**	09/12/2022

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	(Resident 217). Findings include: On 81/22 at 11:55 a.m., Licensed Practical Nurse (LPN) 35 asked Certified Nursing Assistant (CNA) 6 how Resident 217 transferred because she needed to assist him to the restroom. CNA 6 indicated to LPN 35, he was a 1-person assist, but the only way he could hear was if he could read your lips. Resident 217 was not wearing hearing aids at that time. During an interview on 8/1/22 at 12:03 p.m., CNA 6 indicated Resident 217 was "very" hard of hearing and needed his hearing aids in. He was confused and asked "a lot" of questions, then would forget the answers. On 8/1/22 at 3:45 p.m., Certified Nursing Assistant (CNA) 6 knocked on Resident 217's room and asked him if he could leave the room so she could clean the floor. Resident 217 indicated, "What? I can't hear you." CNA 6 pointed toward the direction of the door and assisted him out of the room. Resident 217 asked, "What am I supposed to do?" CNA 6 indicated, "just wait there for a minute so I can clean your room." Resident 217 shrugged and began to roll away. He was not observed to wear hearing aids at this time. During an interview on 8/2/22 at 9:25 a.m., Resident 217 was observed as he laid in his bed. He was "very" hard of hearing. Questions were typed on a laptop computer using extra-large bold letters and read aloud slowly. Resident 217 was able to read along and hear enough to answer simple yes or no questions. He indicated he did not know where his hearing aids were. He did not know if he was supposed to be in bed, or if he was		This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure resident who was hard of hearing had baselines care plan to address his specific need for resident #217. **Corrective Action for resident(s) found to have deficient:** Comprehensive care plan for resident #217 was reviewed and did address his specific hearing needs. **Identify other residents having same potential deficient:** Residents admitted to facility with specific hearing needs prior to having comprehensive care plan completed. No other effected residents were identified. **Measures put into place or systemic changes:** The Assistant Director of Nursing, Director of Nursing, or designee will provide education to the license nurses on baseline care plan accuracy regarding specific hearing needs of	

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	going to go home. Resident 217 pointed at the computer, smiling, and repeated, "that's neat, where did you get that? Can I have one?" During an interview on 8/2/22 at 10:05 a.m., CNA 6 indicated it was hard for him to understand, he was confused, and "very" hard of hearing. He was supposed to wear hearing aids, but she did not know where they were. Resident 217 continued to call out, "Hey! Come here a minute!" On 8/3/22 at 10:12 a.m., Resident 217 was observed at the dining room table. He indicated, "Hey! When I get done eating, what do I do?" LPN 38 indicated, "You can lay down if you want." Resident 217, "I can't hear you." LPN 38 repeated herself, several times, louder each time, but Resident 217 continued to shake his head and indicated, he could not hear her. LPN 38 patted his back and indicated, "I know." When he finished eating, he asked, "are you going to put me to bed?" LPN 38 told him yes, but he replied, "I can't hear you." LPN 38 removed him from the dining room table and assisted him to his room. Resident 217 was not observed to have hearing aids in at this time. During an interview on 8/4/22 from 9:17 a.m., Speech Therapist (ST) 39 indicated, Resident 217 did have a pair of hearing aids that made it a little easier to communicate with him, but they had not been charged last night so they had just been placed on the charger. Even with his hearing aids in, he was still confused, and it was hard to know what he wanted to do. On 8/5/22 at 12:00 p.m., an interview was conducted with the Activity Director (ED) and Executive Director (ED). The AD indicated Resident 217 was "very" hard of hearing. As for		new admission. PRN nurses will receive education prior to their first scheduled shift. **Plan to monitor performance to maintain compliance:** The Director of Nursing, Assistant Director of nursing, or designee will audit new admission baseline careplans on the next business day to ensure specific hearing needs were addressed. Audit will take place for 6 months. If any compliance trends are identified, they will be reviewed in QAPI meeting. **Date of Compliance: 9/12/22**	

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	his hearing aids, she had never seen him wearing any, and did not know if he had a pair or used them. It was hard to communicate with him because of his hearing loss and confusion, and she had not tried any other types of communication methods such as a communication board, white board, or visual cue cards. During an interview on 8/5/22 at 12:36 p.m., the Social Service Director (SSD) indicated each department head was responsible for filling out their corresponding section of the Baseline Care plan. The Baseline Care Plan was usually initiated by the admitting nurse, and then filled out by the appropriate staff. The purpose of the Baseline Care Plan was to identify and capture the most important things required for initial care upon a new resident's admission, so it was important to be filled out entirely and as accurately as possible. On 8/5/22 at 11:57 a.m., Resident 217's medical record was reviewed. He admitted to the facility on 7/15/22 with diagnoses which included but were not limited to dementia and recurrent major depressive disorder. He had a current physician order, dated 7/21/22, which indicated, "Nurse to ensure resident's hearing aids are charging at night and ensure they are in his ears every day." His admission Minimum Data Set (MDS) assessment, dated 7/22/22, indicated he was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 8. He was moderately hard of hearing with the assistance of hearing aids and required extensive assistance with his ADLS (activities of daily living).			

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	A Baseline Care plan was initiated on 7/15/22 and closed on 7/25/22. Section C for Vision and Hearing was blank and did not indicate that Resident 217 was hard of hearing and required the assistance of hearing aid assistive devices. On 8/5/22 at 3:00 p.m., the Director of Nursing provided a copy of current facility policy titled, "Care Plans- Baseline," dated 5/27/20. The policy indicated, " ... A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission ... the interdisciplinary team will review the healthcare practitioner's orders (e.g. dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to ... physician orders ...."			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40			

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	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.			
	Based on observation, interview, and record review, the facility failed to ensure a resident with a diagnosis of type II diabetes mellitus had a comprehensive person-centered care plan to identify risks and implement interventions to manage her diabetic condition (Resident 46), and a resident who received supplemental oxygen (O2) via Hospice orders had a comprehensive care plan to address her specific O2 therapy needs (Resident 43) for 2 of 20 residents reviewed for comprehensive care plans. Findings include: 1. During an interview on 8/4/22 at 10:27 a.m., Licensed Practical Nurse (LPN) 23 indicated,	F 0656	The Restoracy of Whitestown Plan of Correction – F656 **Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law.	09/12/2022

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	Resident 46 was a "brittle" and unpredictable diabetic. Her blood sugar readings did fluctuate "a lot" so the nurses did regular blood sugar checks via her "Libre" device. She was on a sliding scale for insulin and did not always follow her diet. On 8/4/22 at 1:30 p.m., Resident 46 was observed as she sat in her wheelchair in her room. Resident 46 indicated she had been having trouble getting her blood sugars under control but "they were working on it." She used to get her finger pricked so many times a day the ends of her fingers were sore, so she was happy to have a new monitoring device. She pointed to the "Libre" device which was located on her left upper arm. Resident 46 indicated she thought the biggest issue for her was her diet. For example, that morning she had been given oatmeal with brown sugar which would raise her blood sugar. She used to only take a pill for her diabetes but was recently put on insulin too so it was taking some time to get adjusted. On 8/5/22 at 11:58 a.m., Resident 46's medical record was reviewed. She admitted to the facility on 2/22/22 with current diagnoses which included but were not limited to type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). Resident 46's comprehensive care plans were reviewed and lacked documentation of a plan to manage her diabetes. A Progress Note, dated 6/3/22 at 10:41 a.m., indicated Resident 46 had emesis (vomit) at 7 a.m., per off going nurse. Her vitals were taken and an Accu-check was done. Her blood sugar (BS) was 568 which was treated with new physician orders of a one time injection of Ceftriaxone (an		**Alleged deficiency:** The facility failed to ensure resident with DMII had comprehensive person-centered care plan to identify risk and implement interventions to manage her diabetic condition and a resident that received supplemental oxygen via hospice orders had a comprehensive care plan to address her specific oxygen therapy needs. **Corrective Action for resident(s) found to have deficient:** Care plan for resident #46 was immediately put into place to address diabetic diagnosis. Care plan for resident #43 was immediately put into place to address her oxygen therapy needs. **Identify other residents having same potential deficient:** All residents receiving oxygen via hospice orders and all residents with DMII diagnosis have the potential to be affected. **Measures put into place or systemic changes:** All residents receiving hospice services were audited to ensure they had a care plan addressing oxygen need, if applicable. All residents with DMII diagnosis were audited to ensure they had a care plan addressing they diabetic needs. No other resident was found to be affected.	

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	antibiotic), IV (intravenous) fluids, and her sliding scale insulin. A follow up progress note, dated 6/3/22 at 1:47 p.m., indicated Resident 46 was more responsive, and her blood sugar had come down to 330 and treated per her sliding scale instructions. She was given soup and crackers for lunch. A Progress Note, dated 6/5/22 at 12:28 p.m., indicated Resident 46's BS was 382. The on-call physician was notified and instructed to use of her sliding scale. Novolog (insulin medication) 8 units was given at this time. A Progress Note, dated 6/5/22 at 4:20 p.m., indicated her BS was 339. The on-call physician gave orders to change physician notification parameters for if her BS was greater than 350. A Progress Note, dated 6/6/22 at 11:25 a.m., indicated the Interdisciplinary team (IDT) met to discuss Resident 46's antibiotic orders. After Resident 46 had an episode of vomiting, change in mental status, and her BS was found to be 568 on 6/3/22. The Nurse Practitioner (NP) ordered labs, urine, IV fluids, and intramuscular (IM) injection of Rocephin due to acute change. Urine was negative and white blood cell count (WBC) was not elevated. She was diagnosed with hyperglycemia and acute kidney injury (AKI). Her repeat labs were redrawn 6/6/22 and no further antibiotic had been ordered. Endocrinology would follow up as well. A Progress Note, dated 6/6/22 at 1:50 p.m., indicated the IDT team also met to discuss a new diabetic ulcer on Resident 46's right heel. Her blood sugars had been elevated due to her recent		**Plan to monitor performance to maintain compliance:** During risk review meeting, all charts will have diagnosis and medication lists reviewed against care plans to ensure that all care plans needed are in place. Any needed care plans will be initiated at that time. IDT team will continue to meet quarterly and review care plans for accuracy and update as needed. If any compliance trends are identified, we will review in QAPI meetings. **Date of Compliance:** 9/12/2022	

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	illness. BS readings have ranged from over 300, at times over 500. The NP ordered insulin based on glucose results. Resident 46 also had 3 doses of IM Rocephin and 2 liters (L) of fluids for hydration. Additional labs were obtained that morning and were pending. New order was obtained for right foot/heel wound, paint with betadine and allow to dry prior to applying non-skids socks- no shoes and heel protection boots were to be worn in bed. A Progress Note, dated 7/10/22 at 2:47 p.m. indicated Resident 46 was noted to be diaphoretic (clammy/sweaty), her Accucheck reading was 66. She was given 120 milliliters of juice at that time and would be rechecked in 15 minutes. On 7/10/22 at 3:05 p.m., Resident 46's BS was rechecked and at 100, with a note that the MD would be notified of the low reading. A Progress Note, dated 7/11/22 at 4:17 p.m., indicated the Residents BS was checked and read 46. She was clammy and even though her eyes were open, she was unable to respond. She was given orange juice then the MD was notified who gave new orders to give 1 injection of Glucagon (a hormone that your pancreas makes to help regulate your BS). Additionally, her lunchtime insulin orders were discontinued, and her dinner insulin was held. Resident 46 was responding better and able to communicate per her norm. A Progress Note, dated 7/12/22 at 5:10 p.m., indicated Resident's BS was 82 at 7 a.m., BS at noon were documented and her medication and Novolog were held per MD order. A Progress Note, dated 7/23/22 at 12:23 p.m., indicated Resident 46's Accucheck was 423. The on-call physician was notified and gave			

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	instructions to give morning diabetic meds and scheduled lunch insulin then recheck in one hour. On 7/23/22 at 2:05 p.m., her BS was down to 387, and the on-call physician was notified. A Progress Note, dated 7/24/22 at 7:15 a.m., indicated Resident 46's Accucheck was 46 at the beginning of the shift. She was given orange juice and crackers, then was conversing with staff and denied symptoms. The on-call physician was notified and gave instructions to recheck in 30 minutes. A Progress Note, dated 7/24/22 at 7:50 a.m., indicated Resident 46's BS was rechecked and read 60. The on-call physician was notified and gave instructions to hold her morning Novolog and call back with Accucheck results when she was finished with breakfast. A Progress Note, dated 7/24/22 at 10:00 a.m., indicated Resident 46 had finished eating breakfast and her Accucheck was 289. The on-call physician was notified and gave new orders to hold Glipizide and Trajenta. A Progress Note, dated 7/31/22 at 2:05 p.m., indicated Resident 46 refused her scheduled Novolog, the on-call physician was notified and gave no new orders. Resident 46 had a baseline A1C lab draw on 2/25/22 after her admission. The results were 6.5 (hemoglobin A1C or HbA1c test is a blood test that measures your average blood sugar levels over the past 3 months). On 6/9/22 her A1c was re-checked and had increased to 10.8. Normal ranges should be between 4.1-6.1			

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	During an interview on 8/5/22 at 9:50 a.m., the Director of Nursing (DON) indicated she had looked at Resident 46's record and also found that there was no diabetic management care plan or physician order for her Libre BS monitoring device and there should have been. The DON indicated nurses had all been in-serviced on the use of the Freestyle Libre system but she did not see a physician order. The DON provided a copy of a new care plan she developed earlier that morning for Resident 46's diabetes management. 2. During an observation of Resident 43 on 8/1/22 at 11:52 a.m., she was observed sitting up in her room in a recliner. She did not have a bed in her room. She indicated that she preferred to sleep in her chair to help with pain and breathing. In the corner of her room two upright green oxygen tanks along with an oxygen concentrator were observed. A reusable container filled with a water and nasal cannula tubing were attached to the concentrator. The tubing and container of water lacked a date. On 8/2/22 at 10:52 a.m., Resident 43 was observed with the oxygen concentrator in her room connected to a reusable container filled with water and attached to nasal cannula tubing. The tubing and container of water was undated. During an interview with Resident 43 on 8/2/22 at 10:55 a.m., she indicated that she had the oxygen in her room for her to use if she needed it. She recently had pneumonia and had shortness of breath at times. Resident 43's record was reviewed on 8/03/22 02:28 p.m. Resident 43 had the following diagnoses, including but not limited to peripheral vascular disease, type 2 diabetes mellitus, mild cognitive impairment, chronic kidney disease, cardiomegaly, anemia, hypertension, angina			

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	pectoris (chest pain), unspecified cirrhosis and chronic pain. A review of Resident 43 record included orders for hospice to evaluate and treat. No orders were documented for oxygen on the Medication Administration Record. A review of the hospice admission record revealed orders for oxygen on 6/12/22. The order read oxygen at 3 liters per minute per nasal cannula as needed for shortness of breath and comfort; apply oxygen per nasal cannula at 0.5-5 liters per minute for dyspnea (difficulty breathing) or shortness of breath, may titrate as needed for comfort. Resident 43's care plans were reviewed. Resident 43 lacked a care plan to address hospice orders for oxygen as needed for shortness of breath and comfort. On 8/4/22 at 1:23 p.m., the Executive Director (ED) provided a copy of current facility policy titled, "Resident Care Plan," dated 5/27/20. The policy indicated " ...The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident ...." 3.1-35(a)			
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--			

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	(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 ensure comprehensive care plans were revised for 4 of 20 residents reviewed for care plan timing and revision (Residents 43, 56, 13, and 21). Findings include: 1. During an observation on 8/1/22 at 11:52 a.m., Resident 43 was sitting up in her room in a recliner. She did not have a bed in her room. She indicated that she preferred to sleep in her chair to help with pain and breathing. During a record review on 8/3/22 at 2:28 p.m., Resident 43 had the following diagnoses, which included, but were not limited to peripheral vascular disease, type 2 diabetes mellitus, mild	F 0657	The Restoracy of Whitestown Plan of Correction- F657 **Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to	09/12/2022

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	cognitive impairment, chronic kidney disease, cardiomegaly, anemia, hypertension, angina pectoris (chest pain), unspecified cirrhosis and chronic pain. A care plan, dated 3/18/22, indicated Resident 43 used transfer rails to enable resident with turning and repositioning in bed with a goal that Resident 43 would continue to utilize transfer rail to enable bed mobility/transfers and not sustain any injury from the transfer rail. Interventions included complete side rail assessment on admission and for significant changes in condition; and encourage and assist as needed with using the transfer rail for mobility. During an interview on 8/4/22 at 2:12 p.m., the DON (Director of Nursing) and MDS (Minimum Data Set) Coordinator were present. Resident 43's care plans were reviewed. The DON and MDS Coordinator indicated the care plans should have been updated. 2. During an observation on 8/1/22 at 11:31 a.m., Resident 56 was observed sitting in his recliner in his room. He did not have a bed in his room. During a record review on 8/4/22 at 10:26 a.m., Resident 56 had the following diagnoses which included but were not limited to secondary malignant neoplasm of other specified sites, ileostomy status, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, presence of a cardiac pacemaker, type 2 diabetes mellitus without complications, heart failure, cognitive communication deficit, iron deficiency anemia, hypertension, anxiety, and pneumonia. A care plan, dated 4/19/21, indicated Resident 56 used transfer rails on the bed to enable turning		ensure comprehensive care plan were revised regarding care plan timing and revision. **Corrective Action for resident(s) found to have deficient:** Residents #43 and #56 care plan was revised to omit side rails as an intervention, as they both are care planned to sleep in a recliner per their preference. Resident #13 care plan was edited to reflect his current catheter orders. Resident #21 care plan was revised in include a hospice care plan and his oxygen usage. **Identify other residents having same potential deficient:** No other residents have the preference to sleep in a recliner without a bed in their room. All residents who have catheter orders, hospice services, or oxygen orders have the potential to be affected. **Measures put into place or systemic changes:** All resident receiving hospice services, oxygen therapy, or have catheters were audited to ensure they have proper care plan in place. No other residents were found to be affected. **Plan to monitor performance to maintain compliance**: During risk review meeting, all charts will have diagnosis and physician	

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	and repositioning in bed with a goal that Resident 56 will continue to utilize rail to enable bed mobility/transfer and not sustain any injury from the transfer rail through. Interventions included complete side rail assessment on admission and for significant changes in condition; and encourage and assist as needed with using the transfer rail with mobility. Resident 56 had a comprehensive care plan, dated 4/27/21, with a problem that Resident 56 used an antidepressant medication, Remeron, as an appetite stimulant related to severe protein malnutrition with a goal that Resident 56 will be free of discomfort or adverse reaction related to antidepressant therapy. Interventions included administer antidepressant medication as ordered by physician, monitor document side effects and effectiveness every shift, educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms of Remeron, and monitor/document/report as needed adverse reaction to antidepressant therapy. Remeron was not listed on Resident 56's physician orders. During an interview on 8/4/22 at 2:12 p.m., the DON (Director of Nursing) and MDS (Minimum Data Set) Coordinator were present. Resident 53's care plans were reviewed, and the DON and MDS Coordinator indicated the care plans should have been updated. 3. During an observation on 8/1/22 at 1:05 p.m., a urinary bag was attached to the frame of Resident 13's bedframe. The contents of the bag were observed. A dignity bag was not observed in place at that time. The bag was on the side of the bed facing the entrance to Resident 13's room.		orders reviewed against care plans to ensure that all care plans have been revised appropriately. Any needed revisions will be initiated at that time. IDT team will continue to meet quarterly and review care plans for accuracy and update as needed. If any compliance trends are identified, we will review in QAPI meetings. **Date of Compliance: 9/12/22**	

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	During an observation on 8/3/22 at 10:00 a.m., a urinary bag was observed attached to the frame of Resident 13's bed on the side of the entrance to room and was inside a blue "dignity" bag. During a comprehensive record review on 8/2/22 at 2:41 p.m., Resident 13 had that following diagnoses which included, but were not limited to Parkinson's disease, dysphagia (difficulty swallowing), protein-calorie malnutrition, BPH (benign prostatic hyperplasia), neuromuscular dysfunction of the bladder, unspecified retention of urine, and dementia. Orders for an indwelling catheter included: On 4/25/22, change foley catheter monthly on the 25th of each month and as needed at bedtime every month staring on the 25th for dislodgement or occlusion, foley 18 French, 30 cc (cubic centimeters) as needed for dislodgement or occlusion. On 3/28/22 flush foley catheter with 50 millimeters of sterile water every day and evening shift for patency. On 2/25/22 empty contents of catheter drainage bag. On 2/5/22 monitor catheter signs and symptoms monitoring: dysuria (painful urination), pain and infection. Review of Resident 13's care plans revealed a care plan, dated 6/30/21, with a problem that Resident 13 has a condom catheter due to BPH with a goal that the resident would not show signs or symptoms of urinary tract infection. Interventions included check tubing for kink each shift, monitor for signs and symptoms of discomfort on urination, monitor, document for pain/discomfort due to catheter, monitor/record/report to MD for			

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signs and symptoms of UTI (urinary tract infection), position catheter bag and tubing below the level of the bladder and away from the entrance of the room door, and cover drainage bag with dignity bag.

During an interview with the DON (Director of Nursing), ADON (Assistant Director of Nursing) and MDS (Minimum Data Set) Coordinator on 8/4/22 at 3:00 p.m., they indicated that Resident 13's indwelling catheter was removed, and he currently had a condom catheter. The DON indicated that Resident 13 went between an indwelling and condom catheter.

During a chart review on 8/5/22 at 2:50 p.m., Resident 13 continued to have orders for an indwelling 18 French, 30 milliliters catheter.

4. During an observation and interview on 8/1/22 at 11:17 a.m., Resident 21 indicated he had oxygen because he cannot breathe without it. He was observed to have an oxygen concentrator in his room connected to a reusable container of water with tubing inserted into his nares. The flow rate of the concentrator was set to 6 liters per minute. The water container and tubing were undated. Resident 21 reported that he was receiving hospice care.

During an observation on 8/2/22 at 11:20 a.m., Resident 21 had oxygen tubing in his nares. The oxygen concentrator was set to 6 liters per minute. A reusable container of water was connected to the concentrator and tubing. The tubing and water container were undated.

During a comprehensive record review, Resident 21 had the following diagnoses but not limited to chronic obstructive pulmonary disease, aneurysm,

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chronic respiratory failure, hypertension, anxiety, and major depression.

Resident 21 had an order, dated 6/27/22, for oxygen continuously via nasal cannula or mask to keep oxygen saturation 90% or greater every shift for COPD (chronic obstructive respiratory disease). Resident 21 had orders to receive hospice services.

Resident 21's care plan, dated 2/19/22, indicated Resident 21 had COPD (chronic obstructive pulmonary disease) with potential for complications/exacerbation. The care plan lacked documentation of the use of oxygen as an intervention.

Resident 21's record lacked a care plan indicating he had a hospice provider service.

During an interview on 8/4/22 at 2:12 p.m., the DON (Director of Nursing) and MDS (Minimum Data Set) Coordinator indicated Resident 21's care plans should have been updated and implemented.

A policy titled, "Resident Care Plan," was provided by the ED (Executive Director) on 8/4/22 at 1:23 p.m., indicated "...The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident...Changes in the resident's condition must be reported to the MDS Assessment Coordinator so that a review of the resident's assessment and care plan can be made...."

3.1-35(c)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155858	A. BUILDING 00 B. WING	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF WHITESTOWN, THE	6712 RESTORACY DRIVE WHITESTOWN, IN 46075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems.			

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	Based on observation, interview, and record review, the facility failed to ensure a resident who was hard of hearing (HOH) had his hearing aids in place as ordered to promote his functional hearing ability for 1 of 1 residents reviewed for hearing and vision (Resident 217). Findings include: On 81/22 at 11:55 a.m., Licensed Practical Nurse (LPN) 35 asked Certified Nursing Assistant (CNA) 6 how Resident 217 transferred because she needed to assist him to the restroom. CNA 6 indicated to LPN 35 he was a 1-person assist, but the only way he could hear was if he could read your lips. Resident 217 was not wearing hearing aids at that time. During an interview on 8/1/22 at 12:03 p.m., CNA 6 indicated Resident 217 was "very" hard of hearing and needed his hearing aids in. He was confused and asked "a lot" of questions, then would forget the answers. On 8/1/22 at 3:45 p.m., CNA 6 knocked on Resident 217's room and asked him if he could leave the room so she could clean the floor. Resident 217 indicated, "What? I can't hear you." CNA 6 pointed toward the direction of the door and assisted him out of the room. Resident 217 asked, "What am I supposed to do?" CNA 6 indicated, "just wait there for a minute so I can clean your room." Resident 217 shrugged and began to roll away. He was not observed to wear hearing aids at this time. During an interview on 8/2/22 at 9:25 a.m., Resident 217 was observed as he laid in his bed. He was "very" hard of hearing. Resident 217 was able to read along with questions typed on a	F 0676	The Restoracy of Whitestown Plan of Correction- F676 **Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure that resident that was hard of hearing had hearing aids in place as ordered to promote his functional ability to hear. **Corrective Action for resident(s) found to have deficient:** Resident #217 no longer is a resident at this facility. **Identify other residents having same potential deficient:** Residents who are hard of hearing utilizing hearing aids to promote the ability to hear. **Measures put into place or systemic changes:** Assistant Director of Nursing or designee will educate nursing staff on ensuring hearing aides are in place as ordered.	09/12/2022

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	laptop with extra-large bold type and was able to hear enough to answer simple yes/no questions. He did not know where his hearing aids were. He did not know if he was supposed to be in bed, or if he was going to go home. Resident 217 pointed at the computer, smiling, and repeated, "that's neat, where did you get that? Can I have one?" During an interview on 8/2/22 at 10:05 a.m., CNA 6 indicated it was hard for Resident 217 to understand, he was confused and "very" hard of hearing, he was supposed to have hearing aids in, but she did not know where they were. Resident 217 continued to call out, "Hey! Come here a minute!" On 8/3/22 at 10:12 a.m., Resident 217 was observed at the dining room table. He indicated, "Hey! When I get done eating, what do I do?" LPN 38 indicated, "You can lay down if you want." Resident 217, "I can't hear you." LPN 38 repeated herself, several times, louder each time, but Resident 217 continued to shake his head and indicated he could not hear her. LPN 38 patted his back and indicated, "I know." When he finished eating, he asked, "are you going to put me to bed?" LPN 38 told him yes, but he replied, "I can't hear you." LPN 38 removed him from the dining room table and assisted him to his room. Resident 217 was not observed to have hearing aids in at this time. During an interview on 8/4/22 from 9:17 a.m., Speech Therapist (ST) 39 indicated Resident 217 did have a pair of hearing aids that made it a little easier to communicate with him, but they had not been charged last night so they had just been placed on the charger now. Even with his hearing aids in he was still pretty confused, and it was hard to know what he wanted to do.		**Plan to monitor performance to maintain compliance**: Social Service Director or designee will perform an audit to ensure hearing aides are in place for those with orders, three times a week x 1 month, once a week x 1 month, and then monthly x 4 months. If any compliance trends are identified, they will be reviewed in QAPI meetings. **Date of Compliance: 9/12/22**	

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	On 8/5/22 at 12:00 p.m., an interview was conducted with the Activity Director (ED) and Executive Director (ED). The AD indicated Resident 217 was "very" hard of hearing. As for his hearing aids, she had never seen him wearing any and did not know if he had a pair or used them. It was hard to communicate with him because of his hearing loss and confusion, and she had not tried any other types of communication methods such as a communication board, white board, or visual cue-cards. On 8/5/22 at 11:57 a.m., Resident 217's medical record was reviewed. He admitted to the facility on 7/15/22 with diagnoses which included but were not limited to dementia and recurrent major depressive disorder. He had a current physician order, dated 7/21/22, which indicated, "Nurse to ensure resident's hearing aids are charging at night and ensure they are in his ears every day." His admission Minimum Data Set (MDS) assessment was dated 7/22/22 and indicated he was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 8. He was moderately hard of hearing with the assistance of hearing aids and required extensive assistance with his activities of daily living (ADLs). He had a comprehensive care plan, dated 7/25/22, which indicated he had impaired cognitive function due to his dementia. Interventions for this plan of care included ask yes/no questions in order to determine his needs and cue, reorient, and supervise as needed.			

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	He had a comprehensive care plan, dated 7/28/22, indicated he had a communication problem related to his hearing deficit. Interventions for this plan of care included staff were to anticipate and meet his needs, be conscious of resident position when in groups, activities, dining room to promote proper communication with others and to allow adequate time to respond, repeat if necessary, do not rush, request clarification from the resident to ensure understanding, face when speaking, make eye contact, turn off TV/audio to reduce environmental noise, ask yes/no questions if appropriate use simple, brief consistent words/cues. Use alternative communication tools as needed. The care plan record lacked documentation of Resident 217's use of hearing aids. An initial Activities Review, dated 7/17/22, included a section titled, "Limitation/Special Needs" and was checked "no," for the question, "should activities be modified to accommodate hearing deficit." An acute Medical Doctor (MD) progress note was dated 8/2/22 and indicated "...He is extremely hard of hearing ...." On 8/4/22 at 9:40 a.m., the Director of Nursing provided a copy of current facility policy titled, "quality of Life- Dignity," dated 5/27/20. The policy indicated, " ...Each resident shall be care for in a manner that promotes and enhances quality of life, dignity, respect and individuality ... treated with dignity means the resident will assisted in maintaining and enhancing his or her self-esteem and self-worth ... staff shall treat cognitively impaired residents with dignity and sensitivity; for example: addressing the underlying motives or			

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	root causes for behaviors ...." 3.1-39(a)			
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 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, interview, and record review, the facility failed to provide one on one activities for residents unable to participate in group activities for 2 of 2 residents reviewed for one on one activities (Residents 28 and 32), and failed to provide group and individual activities which provided meaningful stimulation and were patterned for interests and hobbies for 2 of 6 facility buildings (Residents 30 and 46). Findings include: 1. On 8/1/22 at 11:08 a.m., during a random observation Resident 28 was seated at the dining room table. Certified Nurse Aid (CNA) 25 was seated across the table looking at her phone. The resident was staring ahead. The television was positioned up high on the wall, above the fireplace. The resident did not appear to notice the television and she never looked up. The resident was confused and disoriented. She did not	F 0679	The Restoracy of Whitestown Plan of Correction- F679 **Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to provide 1:1 activities for residents unable to participate in group activities. Failure to provide group and individual activities which provide meaningful stimulation and	09/12/2022

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	converse or respond to questions appropriately. On 8/2/22 at 9:31 a.m., during a random observation, Resident 28 was seated at the table. She had just finished breakfast. She stared straight ahead and looked down. The television was on, but she did not look up. On 8/3/22 at 1:41 p.m., the medical record was reviewed for Resident 28. The diagnoses included but were not limited to, cerebral infarction (stroke), anxiety disorder and major depression. A current care plan indicated Resident 28 had a communication problem related to dementia. She was rarely understood and rarely understood others. Another current Care Plan indicated Resident 28 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits and physical limitations related to dementia. The goal indicated Resident 28 would participate in activities of choice 3 to 5 times weekly by next review date. She would join her housemates thru the day watching game shows and movies. She also engaged with the cook playing balloon toss. Interventions were for all staff to converse with her while providing care, encourage ongoing family involvement, and invite the resident's family to attend porch visits. Staff were to ensure that the activities the resident was attending were: Compatible with physical and mental capabilities; Compatible with known interests and preferences; Adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation); Compatible with individual needs and abilities; and Age appropriate. Resident 28 needed assistance with ADLs as required during the activity. Resident 28		were patterned for interest and hobbies. **Corrective Action for resident(s) found to have deficient:** Residents #28 and #32 were reassessed for their specific needs and 1:1 activities planned and scheduled. Residents will be reassess for preferences and activity will be designed for the meaningful stimulation and pattern for interest and hobbies. **Identify other residents having same potential deficient:** Residents that do not have the ability to participate in group activities have the potential to require 1:1 activities. All residents have the potential to be affected by the need to activities that provide meaningful stimulation and are patterned for their interests and hobbies. **Measures put into place or systemic changes:** Activities Director will design an activity calendar that reflects 1:1 activities for those who are unable to participate in group activities. The Activity Director will recreate an activity calendar that provides meaningful stimulation and pattern for interest and hobbies of the residents. Assistant Director of Nursing or designee will educate the nursing staff will be educated on the updated activity calendar.	

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	needed assistance/escort to activity functions. Resident preferred activities which did not involve overly demanding cognitive tasks. Engage in simple, structured activities such as music, sensory stimulation. Preferred activities were attending church services in the house and playing balloon toss. 2. On 8/1/22 at 11:20 a.m., during a random observation, Resident 32 was seated at the dining room in front of the television, in her Broda (specialized high back wheelchair) chair. She occasional glanced upward but did not engage in watching the television show. The resident was confused and disoriented. She did not converse or respond to questions appropriately. On 8/2/22 at 9:21 a.m., during a random dining observation, Resident 32 was seated at the dining room in front of the television, in her Broda (specialized high back wheelchair) chair. She occasional glanced up at the television. The television was on. On 8/3/22 at 12:37 p.m., the medical record was reviewed for Resident 32. The diagnoses included but were not limited to anxiety disorder, dementia, hallucinations, cataracts, and chronic pain. A current Care Plan indicated Resident 32 had impaired visual function related to low vision diagnosis of left eye. She had dementia and could not participate with a vision screen. She did follow movement with her eyes. A current activity care plan indicated the resident had a low participation in group activity. She enjoyed music, watching TV, religious activities and snacks. The resident also enjoyed being read to and going outside when it is nice out. The goal		**Plan to monitor performance to maintain compliance**: The Executive Director will assess the activity calendar to ensure 1:1 activities are present for those who are unable to participate in group activities, and has meaningful stimulation and is patterned for interest and hobbies for the residents. This audit will occur monthly x 6 months. If any compliance trends are identified, they will be reviewed in QAPI meetings. **Date of Compliance: 9/12/22**	

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	indicated the resident would "engage in one-on-one activities 2 x [times] a week such as being read to, listening to music and or having snacks. The interventions were during one-on-one visits offer to read devotions, poems and or short stories. During one-on-one visits play music or show musical programs on the TV. Give positive affirmations for engaging in one-on-one activities. Provide one-on-one activity twice a week." Another Current Care Plan indicated the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits. The goal indicated Resident 32 would attend activities 1 to 3 times weekly through the next review date. The interventions listed were for "All staff to converse with [resident] while providing care. Encourage ongoing family involvement. Invite her family to attend porch visits. Ensure that the activities [resident] is attending are: Compatible with physical and mental capabilities; Compatible with known interests and preferences; Adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), Compatible with individual needs and abilities; and Age appropriate. [Resident] needs assistance with ADLs as required during the activity. [Resident] needs assistance/escort to activity functions." 3. On 8/1/22 at 11:30 a.m., the activity calendar was observed by the visitor's entry door, Building 3. All morning activities were television or video application channels from 9:30 a.m. to 1:00 p.m. 2:00 p.m. Craft 3:00 p.m. Porch time and water plants 4:00 p.m. Puzzle time 6:00 p.m. Here comes the Boom comedy on a			

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	video application channel On 8/2/22 at 9:22 a.m., during a random observation, the television was on a criminal show with fighting and action. On 8/2/22 at 9:38 a.m., the television channel was changed by an unidentified Certified Nurse Assistant (CNA) to a western. On 8/2/22 at 9:44 a.m., a review of the activity calendar showed Chair Exercises on a video application channel for 9:30 a.m., coloring pages at 10:15 a.m., and an older sitcom on a video application channel at 11:30 a.m. On 8/3/22 at 11:15 a.m., during an interview with the Director of Nursing (DON) she indicated the Activity Coordinator (AC) arrived at work at 7:00 a.m. each day. The CNAs were responsible to change the channels on the televisions to be sure they agreed with the activity calendar. The AC did a hands-on activity in each home every day. On 8/3/22 at 1:53 p.m., during a random observation in Building 3, a nature show was on the television. The activity calendar indicated "you tube TV - TV trivia." The Calendar indicated AC in the building at 2:00 p.m. CNA 26 was observed trying to put the common room television on for a movie scheduled at 2:00 p.m. A bag of store-bought popcorn was on the kitchen counter. There were 2 residents in the common area (Residents 30 and 46). All other residents were in their rooms. No one was observed going to the rooms to invite the residents to the activity. On 8/3/22 at 2:02 p.m., during a random observation in Building 4, the activity calendar indicated Popcorn and a movie at 1:00 p.m. The			

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	AC was "in this house at 1:00 p.m." daily per the printed calendar. Two unidentified residents were seated at the dining room table painting with CNA 27. One unidentified resident was eating lunch at the table. No other residents were present in the communal area. On 8/3/22 at 11:54 a.m., during an interview, the AC indicated she had worked at the facility since August of 2020. She was initially a cook. She had a certification for activities completed in July of last year. The calendar was a little bit different for each home, based on interest and ability. The CNAs were supposed to turn on the television shows. Each calendar designated when the AC was in that building each day. She did not have one on one activities. Unfortunately, she was not able to do one on ones with residents with having to manage activities of all 6 buildings. Residents 28 and 32 were able to participate in some activities such as church service, even if they could not actively participate in activities they were present when other residents were participating. Sometimes the aids took them outside. The cook in that building was really good with the residents and sometimes did some things with them. On 8/4/22 at 9:06 a.m., the DON provided a current policy, dated 5/27/20, titled, "Activities Program Policy." This policy indicated, "To support our vision of enjoying each day, connecting with others and balancing meaningful homelife tasks with leisure pursuits, the Restoracy offers daily activity programs...An assessment of each resident's interests, hobbies, and preferred patterns of activity will be completed as part of the process, with each comprehensive Minimum Data Set (MDS) assessment, and periodically updated as part of the care planning process.			

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	Activity options will be offered in consideration of the individual cognitive level based on the Allen Cognitive Level Stage (ACLS) or other assessments, with the goal of matching best ability to function with just right challenges and personal preferences. Residents, including those unable to leave their rooms, may choose to take part in a variety of activities...." 3.1-33(a)			
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 ensure residents with diagnoses of type II diabetes mellitus had physician's orders for their subcutaneous glucose monitoring devices with parameters and instructions for monitoring and assessing the device and application site for 2 of 2 residents revived for glucose monitoring (Residents 40 and 46). Findings include: 1. During an interview on 8/4/22 at 10:27 a.m., Licensed Practical Nurse (LPN) 23 indicated Resident 46 was a "brittle" and unpredictable diabetic. Her blood sugar readings did fluctuate a lot, so the nurses did regular blood sugar checks	F 0684	The Restoracy of Whitestown Plan of Correction- F684 **Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failure to	09/12/2022

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	155858	A. BUILDING 00 B. WING	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF WHITESTOWN, THE	6712 RESTORACY DRIVE WHITESTOWN, IN 46075

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	via her Libre (brand name/subcutaneous glucose monitoring device). She was on a sliding scale for insulin and did not always follow her diet. On 8/4/22 at 1:30 p.m., Resident 46 was observed as she sat in her wheelchair in her room. Resident 46 indicated she had been having trouble getting her blood sugars under control but "they were working on it." She used to get her finger pricked so many times a day the ends of her fingers were sore, so she was happy to have a new monitoring device. She motioned to the Libre which was located on her left upper arm. Resident 46 indicated she thought the biggest issue for her was her diet, for example that morning she had been given oatmeal with brown sugar, which would raise her blood sugar. She used to only take a pill for her diabetes but was recently put on insulin too, so it was taking some time to get adjusted. On 8/5/22 at 11:58 a.m., Resident 46's medical record was reviewed. She admitted to the facility on 2/22/22 with current diagnoses which included, but were not limited to, type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). She had a current physician order to complete Accuchecks each morning and evening with instructions to contact the doctor if her blood sugar (BS) was below 70 or greater than 350. There was no physician's order for the Freestyle Libre blood glucose monitoring device. Resident 46's nursing progress notes were reviewed and revealed the following: On 6/3/22 at 10:41 a.m., Resident 46 had emesis		ensure residents with the diagnosis of DMII had physician orders for subcutaneous device with parameters, instructions to monitor and assess the device and application site for resident #40 and #46. **Corrective Action for resident(s) found to have deficient:** Records for residents #40 and #46 were corrected to reflect the subconscious monitoring device with parameters, instructions to monitor and assess the device and application site. **Identify other residents having same potential deficient:** All current residents with subcutaneous devices have been audited by the Director of Nursing and/or Assistant Director of Nursing ensuring orders reflected the subcutaneous device with parameters and instructions to monitor and assess the device and application site. **Measures put into place or systemic changes:** The Assistant Director of Nursing or designee will provide education to the licensed nurses regarding the need for resident with DMII orders to reflect the subcutaneous glucose device with parameters and instructions to monitor and assess the device and application site. PRN nurses will receive education prior to their	

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	(vomit) at 7 a.m., per off going nurse. Her vitals were taken, and an Accu-check was done. Her blood sugar was 568 which was treated with new physician orders of a one time injection of Ceftriaxone (an antibiotic), IV (intravenous) fluids, and her sliding scale insulin. A follow up progress note, dated 6/3/22 at 1:47 p.m., indicated Resident 46 was more responsive and her blood sugar had come down to 330 and treated per her sliding scale instructions. She was given soup and crackers for lunch. On 6/5/22 at 12:28 p.m., Resident 46's BS was 382. The on-call physician was notified and instructed use of her sliding scale. Novolog (insulin medication) 8 units were given at this time. On 6/5/22 at 4:20 p.m., her BS was 339. The on-call physician gave orders to change physician notification parameters for if her BS was greater than 350. On 6/6/22 at 11:25 a.m., the Interdisciplinary Team (IDT) met to discuss Resident 46's antibiotic orders. After Resident 46 had an episode of vomiting, change in mental status, and her BS was found to be 568 on 6/3/22. She was diagnosed with hyperglycemia and AKI (acute kidney injury). Her repeat labs were redrawn 6/6/22 and no further antibiotic had been ordered. Endocrinology would follow up as well. On 6/6/22 at 1:50 p.m., the IDT team also met to discuss a new diabetic ulcer on Resident 46's right heel. Her blood sugars had been elevated due to her recent illness. BS readings have ranged from over 300, at times over 500. The NP has ordered insulin based on glucose results.		first scheduled shift. **Plan to monitor performance to maintain compliance:** The Director of Nursing, Assistant Director of nursing, or designee will audit newly obtained subcutaneous glucose monitoring orders on the next business day to ensure the order states the parameters, instructions to monitor and assess the device and application. If any compliance trends are identified, they will be reviewed in QAPI meeting. **Date of Compliance: 9/12/22**	

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	On 7/10/22 at 2:47 p.m. Resident 46 was noted to be diaphoretic (clammy/sweaty), her Accucheck reading was 66. She was given 120cc of juice at that time and would be rechecked in 15 minutes. On 7/10/22 at 3:05 p.m., Resident 46's BS was rechecked and down to 100, with a note that the MD would be notified of the low reading. On 7/11/22 at 4:17 p.m., the Residents BS was checked and read 46. She was clammy and even though her eyes were open, she was unable to respond. She was given orange juice then the MD was notified who gave new orders to give 1 injection of Glucagon (a hormone that your pancreas makes to help regulate your BS). Additionally, her lunchtime insulin orders were discontinued, and her dinner insulin was held. Resident 46 was responding better and able to communicate per her norm. On 7/12/22 at 5:10 p.m., Resident's BS was 82 at 7 a.m., BS at noon were documented and her medication and Novolog were held per MD order. On 7/23/22 at 12:23 p.m., Resident 46's Accucheck was 423. The on-call physician was notified and gave instructions to give morning diabetic meds and scheduled lunch insulin then recheck in one hour. On 7/23/22 at 2:05 p.m., her BS was down to 387, and the on-call physician was notified. On 7/24/22 at 7:15 a.m., Resident 46's Accucheck was 46 at the beginning of the shift. She was given orange juice and crackers, then was conversing with staff and denied symptoms. The on-call physician was notified and gave instructions to recheck in 30 minutes.			

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	On 7/24/22 at 7:50 a.m., Her BS was rechecked and read 60. The on-call physician was notified and gave instructions to hold her morning Novolog and call back with Accucheck results when she was finished with breakfast. On 7/24/22 at 10:00 a.m., Resident 46 had finished eating breakfast and her Accucheck was 289. The on-call physician was notified and gave new orders to hold Glipizide and Trajenta. On 7/31/22 at 2:05 p.m., Resident 46 refused her scheduled Novolog, the on-call physician was notified and gave no new orders. Resident 46 had a baseline A1C lab draw on 2/25/22 after her admission. The results were 6.5 (hemoglobin A1C or HbA1C test is a blood test that measures your average blood sugar levels over the past 3 months). On 6/9/22 her A1C was re-checked and had increased to 10.8. Normal ranges should be between 4.1-6.1 During an interview on 8/5/22 at 9:50 a.m., the Director of Nursing (DON) indicated she had looked at Resident 46's record and also found that there was no physician order for her Libre BS monitoring device and there should have been. The DON indicated nurses had all been in-serviced on the use of the Freestyle Libre system, but she did not see a physician order. 2. On 8/2/22 at 10:29 a.m., during an observation and interview, Resident 40 indicated the facility did not treat her blood sugars correctly. They kept changing her insulin and they did not listen to her. "I'm in my right mind and handled it for years." A beeping noise was heard coming from a small monitoring device on the resident's over bed table. The resident indicated she had a reader on			

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	her arm for her blood sugar monitor. She picked up the monitor and held it to her left upper arm. The monitor registered 270 (high blood sugar). The facility monitored her blood sugars at certain times, but she liked to keep up with it herself. On 8/3/22 at 2:15 p.m., Resident 40's medical record was reviewed. The diagnoses included, but were not limited to, heart failure, chronic kidney disease and diabetes. A physician's order, dated 3/26/22, indicated "ACCU CHECK [a type of finger stick blood sugar monitoring] in the morning for DM [diabetes] AND in the evening for dm [diabetes]AND in the afternoon for dm [diabetes] AND at bedtime for dm [diabetes]." The blood sugar readings were recorded on the resident record as indicated. There was no order for a Free Style Libre monitoring device. There was no order to assess the device or change the subcutaneous patch on the resident's arm. There were no assessments in the record of the site itself. On 8/4/22 at 3:11 p.m., during an interview, the Director of Nursing (DON) indicated Resident 40 had a Free Style Libre. It had to be changed out every 14 days. The nurse should have been assessing the site daily and there should have been a care plan in place. The assessment and site change should have been documented in the medical record. On 8/5/22 at 9:10 a.m., the DON provided a copy of current facility policy titled, "Continuous Glucose monitoring Policy," dated 5/27/20. The policy indicated, "Residents will have glucose monitoring performed by a licensed nurse or qualified medication aide within the home. The			

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	preferred method of glucose monitoring is by use of a continuous glucose monitor ...." 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a treatment cart was locked when a nurse was not present for 1 of 1 random observation, and ensure medications were not left at the bedside for residents without a self-administer order and evaluation for 2 of 5 residents reviewed for medication administration (Residents 26 and 267). Findings include: 1. On 8/1/22 at 9:45 a.m., during an initial tour and observation in Building 4, the treatment cart was observed unlocked. A bottle of COVID-19 liquid antigen was on top of the cart. There were 4 residents at a table in front of the treatment cart. An unidentified Certified Nurse Assistant (CNA) was observed as she walked around the common area doing an activity with the residents. She came and went from the area and was not with the residents at all times. A visitor entered and sat with the residents as they completed a snowman craft.	F 0689	The Restoracy of Whitestown Plan of Correction-F689 **Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure treatment cart was locked when nurse was not present x 1. Failed to ensure medication were not left at bedside for those without self-administration orders for residents #26 and #267.	09/12/2022

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	On 8/1/22 at 10:10 a.m., during a continuous observation the treatment cart remained unlocked. A visitor and 4 residents remained at the table approximately 4 feet away. There were no staff present at this time. On 8/1/22 at 10:27 a.m., Licensed Practical Nurse (LPN)23 entered the building. She indicated she was responsible for the residents in buildings 3 and 4. She had been building 3. The treatment cart should not have been unlocked. It must have been left open from night shift. 2. On 8/1/22 at 10:14 a.m., during the initial tour and observation of building 4, Resident 26 had a bottle of Flonase nasal spray on her overbed table. The order indicated "Flonase Allergy Relief Suspension (Fluticasone Propionate), 1 spray in both nostrils in the morning for allergies AND 1 spray in both nostrils at bedtime for allergies." On 8/3/22 at 9:52 a.m., Resident 4's medical record was reviewed and lacked documentation of a physician order and/or an assessment of her ability to self-administer her medication. 3. On 8/4/22 at 8:51 a.m., during a medication pass observation, Licensed Practical Nurse (LPN) 24 was observed as she prepared medications at the medication cart for Resident 267. She verified the physician's order and placed the resident's eight oral medications in a pill cup. Then she removed three inhalers from the medication and took them, along with the cup of prepared oral medications and a cup of applesauce to the resident's room. Resident 267 was observed seated in a chair at her bedside. The over the bed table was in front of her. LPN 24 greeted the resident and placed the		**Corrective Action for deficient:** The treatment cart was locked by assigned charge nurse immediately after becoming aware. Nurse of resident #26 was educated on the policy for medication administration, including but not limited to medication being left at bedside. Resident #267 is no longer a resident. **Identify same potential deficient:** Facility audit was performed checking all treatment carts to ensure all were locked when out of view of assigned nurse. There were no identified unlocked treatment carts at that time. All residents have the potential to be affected by this deficient, a facility walk-through was performed by the Director of Nursing and the Assistant Director of Nursing, with no other resident noted to be affected. **Measures put into place or systemic changes:** The Assistant Director of Nursing or designee will provide education to the license nurses and qualified medication aide on the policy/procedures of locking treatment carts when not in view and medication administration policy, including but not limited to leaving medications at bedside. PRN nurses will receive education prior to their first	

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	cup of pills, applesauce and inhalers on the over bed table, in front of the resident. She indicated to the resident to take her pills and not forget her inhalers. She would be back later to get her inhalers (to put back in storage). The nurse left the room before the resident took her medication or inhalers. On 8/4/22 at 9:08 a.m., during an interview, LPN 24 indicated Resident 267 got anxious if you watched her take her medications. She did not have an order to self-administer but she could write an order if she needed to. A resident who self-administered their own medications had to have an evaluation and order to do so. On 8/3/22 at 9:05 a.m., the Director of Nursing (DON) provided a current policy, dated 5/27/20, titled, "Security of Medication Cart." This policy indicated "...Medication carts must be securely locked at all times when out of the nurse's view...." On 8/3/22 at 9:05 a.m., the DON provided a current policy, dated 5/27/20, titled "Medication Administration General Guidelines Policy." This policy indicated, " ...The facility will provide appropriate care and services to manage the resident's medication regimen to avoid unnecessary medications and minimize negative outcomes. The licensed nurse and or QMA [Qualified Medication Aid] shall administer each resident's medications in accordance with the physician's order and the resident's plan of care...Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with self-administration medication policy of the facility...." 3.1-45(a)(2)		scheduled shift. **Plan to monitor performance to maintain compliance:** Director of Nursing, Assistant Director of Nursing, or designee will perform random audit on all treatment carts at a minimum of 3 times a week in all homes x 1 month, then 2 times a week for all homes x 1 month, once a week x 1 month, then every 2 weeks for 3 months. Audit will ensure all treatment carts are locked per our policy/procedure. Director of Nursing, Assistant Director of Nursing, or designee will perform random medication administration competencies with license nurses and qualified medication administrators one time a week x 6 months. If any compliance trends are identified, they will be reviewed in QAPI meeting. **Date of Compliance: 9/12/22**	

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure a resident's personal preference for catheter supplies was	F 0690	The Restoracy of Whitestown Plan of Correction- F690	09/12/2022

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	honored and failed to ensure the catheter bag and tubing was not in contact with the floor, in order to reduce the potential for infections for a resident with a history of urinary tract infections (UITs) for 1 of 3 residents reviewed for catheters/UTIs (Resident 222). Findings include: On 8/1/22 at 12:11 p.m., Resident 222 was observed as he sat in his wheelchair in his room. Upon entrance into his room, his catheter drainage bag and tubing were observed on the floor. When asked about his catheter, Resident 222 picked up the bag, pointed to the clip, and indicated they must have forgotten to clip it somewhere and he attempted to hang the bag on the side of his wheelchair (WC), but it slid off. Resident 222 placed his drainage bag on top of his bed. The nurse was called for assistance. Licensed Practical Nurse (LPN) 35 entered the room and indicated his catheter bag should be attached and kept off the floor at all times to reduce the potential for infections or contamination. When she picked the drainage bag off the bed and stood beside him to look for a place to secure the bag, the bag was above the level of the bladder. As she passed the bag from one hand to the other it swung the tubing, with urine visible in the line, above the level of his bladder. On 8/2/22 at 9:38 a.m., Resident 222 was observed at the dining room table where he finished his morning coffee. At this time, his catheter tubing was noted to touch the floor. There was a moderate amount of light yellow and cloudy urine observed in the tubing. During an interview on 8/2/22 at 9:45 a.m.,		**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failure to ensure a resident's personal preference for catheter supplies was honored and failed to ensure catheter bag and tubing was not in contact with the floor for resident #222. **Corrective Action for resident(s) found to have deficient:** Resident was interviewed by nurse to document personal catheter supply preferences. Catheter bag and tubing were secured as to not be in contact with the floor. **Identify other residents having same potential deficient:** Initial audit was conducted by the Director of Nursing and Assistant Director of Nursing on all residents with catheters, to determine personal preferences for catheter supplies and to ensure catheter bag and tubing were secured as to not be in contact with the floor.	

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	Resident 222 indicated he had his catheter for a while now and had some problems with UTIs before. At this time, the Staffing Coordinator indicated he was ready to help Resident 222 get his new catheter in place. On 8/2/22 at 9:59 a.m., the Staffing Coordinator exited Resident 222's room. Resident 222 was wearing a pair of shorts and a new leg drainage bag was observed in place secured to his right leg, just above his knee. Resident 222 indicated he had just been told earlier that morning that he was supposed to wear a leg bag when he came out of his room. Resident 222 did not like the leg bag style, because it irritated and scratched his skin, but since it was facility policy, he agreed to put it on. During an interview on 8/2/22 at 10:02 a.m., the Staffing Coordinator indicated, Resident 222 was supposed to have a leg bag on earlier, but he did not want it. The Staffing Coordinator had gone in to remind him he was supposed to have a leg bag on to come out of the room and Resident 222 changed his mind and agreed to wear it. On 8/2/22 at 2:52 p.m., Resident 222 was observed as he was assisted out of his room and down to the therapy room. He was wearing shorts, so that his catheter drainage leg-bag was visible above his right knee. The drainage bag was approximately 1/4 full of clear yellow urine. On 8/3/22 at 9:32 a.m., Resident 222 was observed in his wheelchair in his room as he worked on a crossword puzzle. His leg bag had been removed and replaced with a drainage bag that hung under his seat. He indicated he did not know why they kept going back and forth about it. The tubing of the catheter was observed to hang lose and		Preferences will be documented in the care plan. **Measures put into place or systemic changes:** The Assistant Director of Nursing will provide education to all nursing staff on the policy for urinary catheter care and maintenance. PRN nurses will receive education prior to their first scheduled shift. **Plan to monitor performance to maintain compliance:** Social Services will add catheter care supply preferences on admission questionnaire and communicate via email to the team for appropriate care planning. Director of Nursing, Assistant Director of Nursing, or designee will perform random audits on all catheters to ensure urinary catheter bag and tubing is secured to avoid contact with floor once a week for 6 months. If any compliance trends are identified, they will be reviewed in QAPI meeting. **Date of Compliance: 9/12/22**	

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	155858	A. BUILDING 00 B. WING	08/05/2022

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	looped as it rested on the floor. There was a moderate amount of yellow cloudy urine with sediment visible in the tubing. On 8/4/22 at 8:43 a.m., Resident 222 was observed sitting in his wheelchair at the dining room table as he ate breakfast. His catheter drainage tube hung lose and rested on the floor. There was a moderate amount of yellow cloudy urine with sediment visible in the tubing. On 8/4/22 at 9:26 a.m., Resident 222 was assisted to the therapy gym. His catheter tubing dragged on the ground as he was rolled in his wheelchair. At the conclusion of his therapy session 8/4/22 at 10:08 a.m., Resident 222 was assisted back to the dining room table. A greater length of his catheter tubing now hung lose on the ground and rested on the floor. There was a moderate amount of yellow cloudy urine with sediment visible in the tubing. During a follow up interview on 8/4/22 at 2:05 p.m., the Staffing Coordinator indicated the facility should always honor resident preference for catheter supplies. If a resident did not want to wear a leg bag, then they should not have to, and the bag as well as the tubing should always remain off the floor. On 8/4/22 at 2:00 p.m., Resident 222's medical record was reviewed. He had recently admitted to the facility in July of 2022 with active diagnoses which included but were not limited to neuromuscular dysfunction of the bladder and a urinary tract infection. He had a physician order for a suprapubic catheter (a surgically created connection between			

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the urinary bladder and the skin used to drain urine from the bladder in individuals with obstruction of normal urinary flow).

The most recent comprehensive assessment was an admission Minimum Data Set (MDS) assessment dated 7/21/22. The MDS indicated Resident 222 was moderately cognitively impaired with Brief Interview for Mental Status (BIMS) score of 10 and had no behaviors (including rejection of care) in the last 7 days.

A Urinalysis lab was completed on 7/18/22. His urine color was turbid and positive for Citrobacter Freundii, a species of bacteria.

A Nurse Practitioner visit note, dated 7/26/22, indicated Resident 222 was being treated for a UTI and despite starting antibiotics 3 days prior to the note, he was still feeling unwell.

A nursing progress note, dated 7/28/22 at 3:02 p.m., indicated Resident 222 was having intermittent confusion and continued to hallucinate off and on. The Nurse Practitioner (NP) had discontinued tramadol and started an antibiotic for "chronic UTI."

A nursing progress note, dated 8/2/22 at 9:39 a.m., indicated, "Tried to put leg bag on resident. He refused stating he didn't like leg bag due to comfort."

Resident 222 had a comprehensive care plan for his suprapubic catheter with interventions which included but were not limited to position catheter bag and tubing below the level of the bladder and cover the drainage bag with a dignity bag.

On 8/4/22 at 9:40 a.m., the Director of Nursing

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	(DON) provided a copy of current facility policy titled, "Management of Indwelling Urinary Catheter," dated 5/27/20. The policy indicated, "...indwelling urinary catheter should not be changed routinely. Catheters should only be changed for a. obstruction b. catheter is leaking, c. physician order to change catheter... keep drainage bag at or below the level of the bladder at all times. Be sure tubing is not kinked, twisted, obstructed, or caught. Keep drainage bag off the floor. Tubing should be secured with a securement device...." 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure supplemental oxygen equipment was stored with labels and dates to ensure appropriate replacements for infection prevention were maintained for (Residents 43, 56, and 21). Findings include: 1. Resident 43 was observed on 8/2/22 at 10:52 a.m., the oxygen concentrator remains in her room connected to a reusable container filled with water	F 0695	The Restoracy of Whitestown Plan of Correction- F695 **Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists	09/12/2022

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	and attached to nasal cannula tubing. The tubing and container of water was undated. During an interview with Resident 43 on 8/2/22 at 10:55 a.m., she indicated that she had the oxygen in her room for her to use if she needed it. She recently had pneumonia and had shortness of breath at times. During a record review on 8/3/22 at 2:28 p.m., Resident 43 had diagnoses including, but not limited to peripheral vascular disease, type 2 diabetes mellitus, mild cognitive impairment, chronic kidney disease, cardiomegaly, anemia, hypertension, angina pectoris (chest pain), unspecified cirrhosis, and chronic pain. Resident 43 had physician orders for hospice to evaluate and treat. No orders were present for oxygen. A review of the hospice admission record revealed orders for oxygen on 6/12/22. The order read oxygen at 3 liters per minute per nasal cannula as needed for shortness of breath and comfort. Apply oxygen per nasal cannula at 0.5 to 5 liters per minute for dyspnea (difficulty breathing) or shortness of breath, may titrate as needed for comfort. 2. During an observation on 8/1/22 at 11:31 a.m., Resident 56 was observed sitting in his recliner in his room. He did not have a bed in his room. Resident 56 had oxygen tubing in his nares. The tubing was connected to a humidified water bottle that was attached to an oxygen concentrator. The flow rate of oxygen was set at 4 liters per minute. The water bottle and oxygen tubing were undated. During an observation on 8/2/22 at 11:01 a.m.,		or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure supplemental oxygen equipment was stored with labels and dates to ensure appropriate replacement for residents 43, 56, and 21. **Corrective Action for resident(s) found to have deficient:** Supplemental oxygen equipment for residents 43, 56, and 21 were replaced and labeled with appropriate date. **Identify other residents having same potential deficient:** Residents within the facility that utilize oxygen and require supplemental equipment. **Measures put into place or systemic changes:** The Assistant Director of Nursing, Director of Nursing, or designees will provide education to the license nurses on the policy related to oxygen supplemental equipment. We will educate oncoming licensed nurses during orientation and reeducate annually. PRN nurses will receive education prior to their first scheduled shift. **Plan to monitor performance to**	

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	Resident 56 was observed in his room, sitting in his recliner. He had oxygen at 4 liters per minute per nasal cannula. The humidified water and oxygen tubing were undated. During a record review on 8/4/22 at 10:26 a.m., Resident 56 had the following diagnoses but not limited to secondary malignant neoplasm of other specified sites, ileostomy status, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, presence of a cardiac pacemaker, type 2 diabetes mellitus without complications, heart failure, cognitive communication deficit, iron deficiency anemia, hypertension, anxiety, and pneumonia. Resident 56 had orders for oxygen at 4 liters per nasal cannula, may titrate to keep oxygen saturation greater than 90%. 3. During an observation and interview of Resident 21 on 8/1/22 at 11:17 a.m., Resident 21 indicated he had oxygen because he could not breathe without it. He was observed to have an oxygen concentrator in his room connected to a reusable container of water with tubing inserted into his nares. The flow rate of the concentrator was set to 6 liters per minute. The water container and tubing were undated. Resident 21 reported that he was receiving hospice care. During an observation on 8/2/22 at 11:20 a.m., Resident 21 had oxygen tubing in his nares. The oxygen concentrator was set to 6 liters per minute. A reusable container of water was connected to the concentrator and tubing. The tubing and water container were undated. During a record review on 8/4/22 at 11:20 a.m., Resident 21 had the following diagnoses but not		**maintain compliance:** The Director of Nursing, Assistant Director of nursing, or designee will audit all residents with supplemental oxygen equipment weekly x 1 month, followed by 2 residents weekly for 1 month, and one resident weekly for 1 month. If any compliance trends are identified, they will be reviewed in QAPI meeting. **Date of Compliance: 9/12/22**	

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	limited to chronic obstructive pulmonary disease, aneurysm, chronic respiratory failure, hypertension, anxiety, and major depression. Resident 21 had an order, dated 6/27/22, for oxygen continuously via nasal cannula or mask to keep oxygen saturation 90% or greater every shift for COPD (chronic obstructive respiratory disease). During an interview with the Director of Nursing (DON) on 8/5/22 at 3:12 p.m., she indicated the equipment should have been changed weekly and dated, to include the water in the containers. A policy and procedure provided by the DON on 8/3/22 at 9:05 a.m., titled, "Oxygen Policy and Procedure" dated 5/27/20, indicated, " ...Oxygen tubing, nasal cannula and/or masks will be replaced weekly, and as needed, humidification containers will be changed as needed, but no longer than one week, oxygen tubing, nasal cannula, and/or mask will be labeled with a date replaced or contained in a bag indicating the date, humidification containers will be dated when replaced...." 3.1-47(a)(6)			
F 0732 SS=E Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly			

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	responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to post accurate staffing daily for 4 of 6 homes at the facility. Findings include: On 8/1/22 at 9:45 a.m., during an initial tour of building 4, the staff posting was observed on the bookshelf in a clear plastic frame. The posting was dated 7/13/22. It indicated Building 4 had 1 "Nurse", and 2 Certified Nursing Assistants	F 0732	The Restoracy of Whitestown Plan of Correction- F732 **Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an	09/12/2022

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	(CNA) for day shift and evening shift. Night shift was 1 nurse 1 CNA. On 8/1/22 at 10:41 a.m., during an initial tour of building 3, a clear plastic frame was observed on the bookcase. The frame was empty. No nursing hours were posted in building 3. On 8/1/22 at 11:34 a.m., the Staffing Coordinator (SC) was observed as he posted the daily staffing for building 3. The posting indicated 1 Nurse and 2 CNA, for day shift. On 8/1/22 at 11:35 a.m., during an interview, the SC indicated the nurse was shared between two buildings. Building 3 and 4 had the same nurse (for the 8-hour shift). The staffing sheet for each of the two buildings showed 1 nurse, but it was the same nurse. He did not know how to show a nurse was shared between two buildings, on the posting. The posting showed the number of people assigned to the building, not the amount of hours. On 8/2/22 at 3:11 p.m., the facility assessment was reviewed along with the nurse staffing schedule and daily posting for one month. The facility assessment indicated, "Days [shift]" Licensed Practical Nurse (LPN), Unit 1 - 8 hours, Unit 2- 12 hours, Unit 3- 4 hours, Unit 4- 4 hours, Unit 5- 4 hours, Unit 6- 4 hours, total nurses 36 hours (Day shift). The daily staffing assessment sheets indicated Day shift Home 3, 8/1/22 daily through 8/4/22 LPN 23, CNA 25 and CNA 26. The daily staffing assessment sheets indicated Day shift Home 4, 8/1/22 daily through 8/4/22 LPN 23, CNA 27 and CNA 28.		admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to post accurate staffing daily. **Corrective Action for deficient:** The Restoracy of Whitestown has revised the staff posting form to ensure accuracy for the entire campus and its posting procedures. **Measures put into place or systemic changes:** Executive Director provided education tothe Staffing Coordinator and designee regarding new staffing forms to ensure accuracy. **Plan to monitor performance to maintain compliance:** Executive Director or designee will audit forms posted in homes daily x 2 weeks, twice a week x 6 weeks, then weekly 2 months. If any compliance trends are identified, they will be reviewed in QAPI meeting. **Date of Compliance: 9/12/22**	

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	On 8/3/22 at 9:05 a.m., the Director of Nursing (DON) provided a current policy, dated 5/27/20, titled, "Posting Direct Care Daily Staffing Numbers." This policy indicated, "Restoracy will post in each home, daily for each shift, the number of nursing personnel responsible for providing direct care to residents...the actual time worked during that shift for each category and type of nursing staff...when computing hours of direct care staff working split shifts, count only the total number of hours the individual is actually scheduled to work for the shift information being posted (example : you are posting data for the Day Shift. A CNA reports to work and is scheduled to work four (4) hours on the Day Shift and four (4) hours on the Evening Shift. In computing the number of hours worked for that shift, count only four (4) hours scheduled for Day Shift and the remaining four (4) hours on the Evening Shift...."			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to ensure person-centered interventions and activities were implemented for a resident with a diagnosis of dementia with behaviors and intrusive wandering for 1 of 3 residents reviewed for activities (Resident 217). Findings include: On 8/1/22 at 11:40 a.m., Resident 217 rolled himself	F 0744	The Restoracy of Whitestown Plan of Correction- F744 **Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an	09/12/2022

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	out of his room. He was wearing a pair of gray sweatpants and a large urine stain had soaked through. There was a smell of urine near him. He asked for something to eat, and how to get to the dining room. Licensed Practical Nurse (LPN) 35 got up from the dining room table where she had been sitting and working on a computer. She assisted him to the table where a plate of food waited for him. On 8/1/22 at 11:54 a.m., Resident 217 attempted to enter 221's room. He was redirected by LPN 35 who assisted him back to the dining room table. The urine stain was still visible on his pants at this time. On 81/22 at 11:55 a.m., LPN 35 asked Certified Nursing Assistant (CNA) 6 how Resident 217 transferred because she needed to assist him to the restroom. CNA 6 indicated to LPN 35, he was a 1-person assist, but the only way he could hear was if he could read your lips. On 8/1/22 at 3:39 p.m., Resident 217 was observed as he exited the therapy room in his wheelchair. The Therapist indicated, "you can go on back to your room now." Resident 217 asked, "which one is my room?" The Therapist pointed down the hall and indicated, "right there at the end of the hall." Resident 217 indicated he could not hear, so the therapist pointed down the hall, and Resident 217 pointed in the same direction. The therapist nodded "yes," and Resident 217 slowly made his way in the direction of his room. Halfway to his room, he stopped and fidgeted with a magazine and a T.V. remote. A visitor was sitting in the lounge area and her phone began to ring. Resident 217 waved and asked, "is that for me?" When she nodded "no," Resident 217 continued on his way, and entered his room.		admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure person centered interventions and activities were implemented for resident with diagnosis with behaviors and intrusive wandering. **Corrective Action for resident(s) found to have deficient:** Resident is no longer a resident in the facility **Identify other residents having same potential deficient:** No other residents were identified as effected. **Measures put into place or systemic changes:** The Social Service Director or designee will provide education to all nursing staff for interventions and activities for residents with intrusive wandering, to include but not limited to person center activities, prevention strategies, distraction, and engagement. Education for PRN nursing staff will take place prior to their next shift if there is a special need on campus. **Plan to monitor performance to maintain compliance:** We will	

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	On 8/1/22 at 3:45 p.m., Certified Nursing Assistant (CNA) 6 knocked on Resident 217's room and asked him if he could leave the room so she could clean the floor. Resident 217 indicated, "What? I can't hear you." CNA 6 pointed toward the direction of the door and assisted him out of the room. Resident 217 asked, "What am I supposed to do?" CNA 6 indicated, "just wait there for a minute so I can clean your room." Resident 217 shrugged and began to roll away. On 8/1/22 at 3:42 p.m., Resident 217 watched a staff person enter the front door. As the door closed behind her, he attempted to keep the door from closing and tried to move forward through the door. The therapist redirected him and asked him to go sit back by the tables. She closed the door so that it locked and continued to the therapy room. No activity or intervention was offered at this time. On 8/2/22 at 10:03 a.m., Resident 217 was observed as he sat on the edge of his bed. He called out, "Hey! Hey!" CNA 6 walked to his door and Resident 217 indicated, "I want to get up." CNA 6 told him to hang on just a minute, she needed to get someone to help. Resident 217 called after her as she walked away, "Hey! I want to get up!" During an interview on 8/2/22 at 10:05 a.m., CNA 6 indicated it was hard for him to understand, he was confused and very hard of hearing, he was supposed to have hearing aids in but she did not know where they were. Resident 217 continued to call out, "Hey! Come here a minute!" On 8/2/22 at 11:11 a.m., Resident 217 completed therapy and was assisted to the common area T.V.		add to annual inservice calendar as appropriate for special needs of the residents on the campus. **Date of Compliance: 9/12/22**	

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	lounge. Resident 217 asked the therapist, (PT 36), "what am I supposed to do? Should I stay?" The PT 36 indicated; he could do whatever he wanted. As the therapist walked back to the therapy room, Resident 217 rolled himself to his room. He asked CNA 6 as she passed by, "What am I supposed to do?" CNA 6 indicated he could lay own until lunchtime. No activity or intervention was offered at this time. On 8/2/22 at 2:51 p.m., Resident 217 was assisted back to his room by Licensed Practical Nurse (LPN) 37. When they entered his room he asked, "Is this my room?" She replied, "Yes." Resident 217 asked, "Well, what do you want me to do?" LPN 37 indicated, "you can just hang out here if you want," and she exited his room. Soon after, Resident 217 rolled out of his room and wandered up the hall. No activities or interventions were offered at this time. On 8/2/22 at 2:53 p.m., Resident 19's bedroom door was left open, and Resident 217 wandered into her room where she was being assisted to use the bathroom by a staff member. CNA 6, who was in the bathroom with the female resident, helped redirect him out of Resident 19's. As he left the room, CNA 6 started to close the door. Resident 217 asked, "where am I supposed to go?" CNA 6 indicated, "you still have crackers on the table, go eat those." CNA 6 closed the bedroom door as Resident 217 indicated, "I don't see them," but the door was closed, and he shrugged his shoulders and wandered into the T.V. lounge. A snack was offered, but no one was available to assisted him to the table or bring his snack to him. During a follow up interview on 8/2/22 at 3:02 p.m., Resident 19 indicated, she had not started using the bathroom when Resident 217 came into her			

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	room, so he had not seen anything, and she was thankful for that. She indicated, "he just does that sometimes." On 8/3/22 at 10:12 a.m., Resident 217 was observed at the dining room table. He indicated, "Hey! When I get done eating, what do I do?" LPN 38 indicated, "You can lay down if you want." Resident 217, "I can't hear you." LPN 38 repeated herself, several times, louder each time, but Resident 217 continued to shake his head and indicated, he could not hear her. LPN 38 patted his back and indicated, "I know." When he finished eating, he asked, "are you going to put me to bed?" LPN 38 told him yes, but he replied, "I can't hear you." LPN 38 removed him from the dining room table and assisted him to his room. Resident 217 was not observed to have hearing aids in at this time, and no activities or interventions were offered. During a continuous observation on 8/4/22 from 8:44 a.m. until 10:00 a.m., the following was observed: At 8:44 a.m., Resident 217 was observed as he finished breakfast in the common area dining room. He unlocked his wheelchair brakes and moved away from the table to the front door and looked outside. As an unidentified therapist entered the building, Resident 217 indicated, "Hey, I have to go pee." The therapist asked nursing staff to assist him. At 8:46 a.m., Resident 217 was assisted to his room by Speech Therapist, (ST) 39. While she waited for a aid, she attempted to have conversation with him about his room and his bed which looked "comfy" but Resident 217 struggled to hear her. ST 39 continued to repeat herself, but Resident 217 shook his head no, that he could not hear her. She rubbed his shoulders and indicated,			

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	"I know, I know." At 8:50 a.m., CNA 6 entered the room with ST 39 and Resident 217 to assist him to the bathroom. At 9:13 a.m., Resident 217 was assisted back out of his room and brought back to the dining room table. When he was seated at his plate he indicated, "Is this mine? I don't want this." LPN 38 indicated she could save it for later and continued to the nurses' medication cart to continue medication pass. At 9:17 a.m., an interview was conducted with ST 39 who indicated, Resident 217 did have a pair of hearing aids that made it a little easier to communicate with him, but they had not been charged last night so they had just been placed on the charger now. Even with his hearing aids in, he was still pretty confused, and it was hard to know what he wanted to do. At 9:19 a.m., Resident 217 indicated, "Hey! Can you hear me? I need to go pee." LPN 38 approached him and gave him a cup of medication. Resident 217 took the pill cup and indicated, "Wow, that's a lot." LPN 38 nodded her head "yes." He took his medication without difficulty. At 9:27 a.m., Resident 217 was brought back out of his room, and asked, "Where am I going? What do you want me to do?" LPN 38 indicated he could finish breakfast. At 9:30 a.m., Resident 217 indicated, "Where is everybody at?" LPN 38 indicated, "I'm behind you." Resident 217 indicated he could not hear her, and he needed to go to the bathroom again. CNA 6 assisted him back to his room. At 9:35 a.m., CNA 6 exited Resident 217's room. His lights were off, and he was observed lying in bed. His eyes were open, and he began to call out, "Hey! Where are you at?" At 9:37 a.m., Resident 217 continued to call out repeatedly, "Hey, where are you at?"			

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	At 9:50 a.m., Resident 217 repeated several times, "Anybody there?" At 10:00 a.m., LPN 38 closed his door. No activities or interventions were offered except toileting and being assisted back to bed. Throughout the survey period, and the above observations in House 2, no scheduled activities were observed. Although an Activity Calendar was posted with daily lists of movies and TV channels, the corresponding shows were not observed to be played. Resident 217 was not observed being invited to or provided with any activities. On 8/5/22 at 12:00 p.m., an interview was conducted with the Activity Director (ED) and Executive Director (ED). The AD indicated; Resident 217 did not have a very good attention span. Even though it was not documented, she had tried several different interventions with him, but he really only liked snacks and sleeping. He was very hard of hearing, so it made it harder for him to participate in group activities, and usually he just came to Bingo for the snacks. As for his hearing aids, she had never seen him wearing any, and did not know if he had a pair. It was hard to communicate with him because of his hearing loss and confusion, and she had not tried any other types of communication methods such as a communication board, white board, or visual cue-cards. The Activity Director indicated most House activities were "Resident initiated" and there was a "general calendar" of TV channels and suggestions that the aids could follow. There was also an activity book full of crosswords, puzzles and word games, but those would be more appropriate for higher functioning residents. Many of the Rehab residents in House 2 were higher functioning and could participate in their			

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	own activities such as provided crosswords and puzzle games, but Resident 217 did not have that capacity. When asked about the procedure for activity interventions for new admission residents, the AD indicated, she did not think interventions were on a CNA assignment sheet, but just through conversation she would let the aids know what types of interventions they could try. Additionally, there was a new admission Resident preference assessment that the AD completed which spoke to the resident's daily routines and preferences and included some things the resident liked. She did not know if the aids had direct access to the assessment, but again, it would be shared with the aids via conversation. On 8/5/22 at 11:57 a.m., Resident 217's medical record was reviewed. He admitted to the facility on 7/15/22 with diagnoses which included but were not limited to dementia and recurrent major depressive disorder. His admission Minimum Data Set (MDS) assessment, dated 7/22/22, indicated he was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 8. He was moderately hard of hearing with the assistance of hearing aids and required extensive assistance with his activities of daily living (ADLs). He had a comprehensive care plan, dated 7/25/22 which indicated he had impaired cognitive function due to his dementia. Interventions for this plan of care included, ask yes/no questions in order to determine his needs and cue, reorient and supervise as needed. He had a comprehensive care plan, dated 7/25/22			

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	which indicated he was dependent on staff to meet his emotional, intellectual, physical and social needs and needed to be encouraged to join activities. Interventions for this plan of care included, but were not limited to, invite to scheduled activities, his preferred activities were fishing and watching movies, provide materials for individual activities as desired. An initial Activities Review, dated 7/17/22, included a section titled, "Limitation/Special Needs" and was checked "no," for the question, "should activities be modified to accommodate hearing deficit." Resident 217's Point of Care record since his admission was reviewed. Tasks to documented emotions, intellectual, outings, physical domain, and social domain programs were all marked "NA." Resident 217's Point of Care record for behavior documentation was reviewed and revealed the following: Upon his first 10 days after admission, there were only 4 coded instances of behaviors. 7/16- rejection of care was checked off once 7/21- yelling/screaming was checked off once 7/22- wandering was checked off once 7/24- wandering was checked off once After 7/25/22 his behaviors increased from occasional to daily and became more aggressive. 7/25- yelling/screaming, threatening behavior, sexually inappropriate behaviors were coded 7/26- repetitive movements and biting were coded 7/28- grabbing, wandering, abusive language, and sexually inappropriate behaviors were coded 7/29- repetitive movements, abusive language and sexually inappropriate behaviors were coded			

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	7/30- pushing was coded 7/31- repetitive movements was coded Resident 217's nursing progress notes were reviewed and revealed the following: On 7/16/22 at 10:45 a.m., he was alert, oriented and able to make his needs and wants known and was sometimes combative/confrontational. On 7/17/22 at 6:44 p.m., he was alert with confusion and non-complaint with isolation precautions. He was incontinent of urine and dumped his urinal on the floor. Even with frequent staff checks, he continued to urinate on the floor. After dinner he urinated on the wall of the activity room. On 7/18/22 at 2:20 p.m., he continued to use the bathroom in inappropriate areas. On 7/28/22 at 2:23 p.m. he continues to be incontinent or urine and use the bathroom in inappropriate area so that staff need to clean his room several times a day, he wanders through the building and goes into other resident's rooms, often forgetting where his room is. Report from night shift indicated he had been touching staff's behind and has gotten close to female residents and tried to exit seek once. On 7/29/22 at 7:03 a.m., he was up through the night, verbally abuse towards staff and continued to try to go into other residents' room and became upset when redirected out of their rooms. On 7/31/22 at 3:39 p.m., he continued to be confused, urinated on the floor and in trash cans. Went in and out of other resident rooms thinking they were his rooms. When redirected to his room, he wandered back out and forgot where his room was. Asks staff and visitors how to get out of here, opened the front door, but staff intervened and easily redirected. On 8/1/22 at 4:09 p.m., Resident 217 was referred to Psych services for medication review and			

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	behavioral episodes including exit seeking. On 8/4/22 at 9:10 a.m., a Social Service not indicated, Resident 217 had been seen by Psych and the doctor recommended discontinuing Aricept due to the possibility of increasing his urine frequency. An acute Medical Doctor (MD) progress note, dated 8/2/22, indicated, "...seen for follow up to left knee pain, continued inappropriate behaviors as nursing reports increased incontinence and urinating all over his room. We meet in his room where he is awake and lying in bed. He is extremely hard of hearing ... speak to the son who is also concerned that he "must have another UTI" because of the increased behaviors reported by nursing staff. Will send U/A C&S ... patient reports urinary loss of control and increased urinary frequency, mood swings, agitation and dementia ...." The progress notes lacked documentation of person-centered activities being offered or interventions put in place to prevent/distract/engage Resident 217, apart from a toileting schedule and redirection of the unwanted behaviors. On 8/4/22 at 9:40 a.m., the Director of Nursing provided a copy of current facility policy titled, "Behavioral Assessment, Intervention and Monitoring," dated 5/27/20. The policy indicated, " ...interventions will be individualized and part of an overall care environment that supports physical functions and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities ... interventions and approaches will be based on a detailed assessment of physical, psychosocial and behavioral symptoms and their underlying			

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	causes, as well as the potential situational and environmental reason for the behavior ...." On 8/4/22 at 9:40 a.m., the Director of Nursing provided a copy of current facility policy titled, "quality of Life- Dignity," dated 5/27/20. The policy indicated, " ...Each resident shall be care for in a manner that promotes and enhances quality of life, dignity, respect and individuality ... Residents shall be assisted in attending the activities of their choice...." 3.1-37(b)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.			

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	§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to ensure an over the counter (OTC) supplement had a complete order in place to indicate how to administer it for 1 of 7 residents reviewed for accidents (Resident 17). Findings include: On 8/3/22 at 3:33 p.m., the medical record was reviewed for Resident 17. A physician's order, dated 3/17/21, indicated, "Ok to use Turmeric as needed ..." The order did not indicate how much or how often. The order gave no indication for the medication's use. On 8/4/22 at 9:08 a.m., during an interview Licensed Practical Nurse (LPN) 24 indicated OTC medications and supplements should have had a physician order which contained all the information to give the medication, resident name, name of medication, how much to give, and how often (frequency). Residents who self-administer and keep medications at the bedside must have an evaluation done and a physician order, otherwise medications cannot be left at bedside. On 8/4/22 at 3:11 p.m., during an interview, the	F 0755	The Restoracy of Whitestown Plan of Correction- F755 **Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure all over the counter supplements had a complete order in place for resident #17. **Corrective Action for resident(s) found to have deficient:** Supplement order for resident #17 was clarified with the medical provider and order now includes dose, frequency, and purpose, as well as residents' preference.	09/12/2022

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	Director of Nursing (DON) indicated OTC medications such as vitamins and supplements must have a doctor's order. The order should indicate name dose/amount and frequency. There was no specific policy for supplements and OTC medications. They follow the "Medication Administration" policy. On 8/3/22 at 9:05 a.m., the DON provided a current policy, dated 5/27/20, titled, "Medication Administration General Guidelines Policy." This policy indicated, "The facility will provide appropriate care and services to manage the resident's medication regimen to avoid unnecessary medications and minimize negative outcomes. The licensed nurse and or QMA [Qualified Medication Aid] shall administer each resident's medications in accordance with the physician's order and the Resident's plan of care...." 3.1-25(j) 3.1-25(k)(4) 3.1-25(k)(5)		**Identify other residents having same potential deficient:** Audit was performed to identify residents that could be affected by this practice, no other residents were identified. **Measures put into place or systemic changes:** Education was provided to medication administrators regarding over-the-counter supplements and appropriate complete orders including but not limited to dose, route, and indication. **Plan to monitor performance to maintain compliance:** The Director of Nursing, Assistant Director of nursing, or designee will audit to identify over the counter supplements in each medication cart and ensure they have a complete corresponding order. Audit will be performed on all medication carts within a 1-week period x 1, then two medication carts per week x 1 month, then one medication cart weekly x 1 month, then two carts per month x 3 months until 100% compliance. All new and re-admission orders for over-the-counter supplements will be audited the next business day to ensure 100% compliance with complete orders. If any compliance trends are identified, they will be reviewed in QAPI meeting.	

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			Date of Compliance: 9/12/22	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as			

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	155858	A. BUILDING 00 B. WING	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF WHITESTOWN, THE	6712 RESTORACY DRIVE WHITESTOWN, IN 46075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview, and record review, the facility failed to ensure that all medications had indications for use for 1 of 5 residents reviewed for unnecessary medications (Resident 41). Findings include: On 8/3/22 at 10:35 a.m., Resident 41's record was reviewed. She was admitted on 1/28/22. On 2/2/22, her diagnoses included, but were not limited to, dementia without behavioral disturbance, (disorder of the brain), anxiety disorder, and major depressive disorder. On 3/2/22, an additional diagnosis was included, psychotic disorder with delusions (severe mental disorder in which reality is lost). A care plan, dated 3/29/22, indicated Resident 41 had behavioral problems related to calling her daughter with delusions of thinking she had been kidnapped and locked in a basement. She had further behavioral episodes of firing staff members and stating, "Let's not play games here. Take your staff and get out." The nursing intervention indicated to administer medications as ordered	F 0758	The Restoracy of Whitestown Plan of Correction- F758 **Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure all medication had an indication for use. **Corrective Action for resident(s) found to have deficient:** The physician order for medication identified for resident #41 was updated with the diagnosis which	09/12/2022

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	and monitor and document for side effects and effectiveness. On 3/3/22 at 12:23 p.m., a Social Services progress note indicated, Resident 41's case was reviewed by her psychiatrist on 3/2/22. She had an increase in symptoms related to psychosis that had been very distressful to the resident. She was started on Zyprexa 2.5 milligrams (mg), by mouth, for psychosis. On 8/2/22 at 2:00 p.m., the Director of Nursing (DON) indicated Resident 41 was started on Zyprexa on 3/2/22. The physician order indicated Zyprexa 2.5 mg. Give 2.5 mg by mouth in the evening. The order was created by the Assistant Director of Nursing (ADON) and did not give an indication for the medications use. During an interview, on 8/5/22 at 2:30 p.m., the ADON indicated she charted the physician's order and had left off the medication's indication for use. During an interview, on 8/5/22 at 2:31 p.m., the DON indicated the medication should have had an indication for use. A current policy, titled, "Medication Administration General Guidelines Policy," dated 5/27/20, was provided by the DON on 8/4/22 at 9:40 a.m. A review of the policy indicated, " ...The facility will provide appropriate care and services to manage the resident's medication regimen to avoid unnecessary medications and minimize negative outcomes ...." 3.1-48(a)(4)		was found in medical record. **Identify other residents having same potential deficient:** Audit was conducted on all other resident with order for psychotropic medication to ensure the indication was documented in the medical record and on their order, with no other residents being effect **Measures put into place or systemic changes:** Education was provided to license nurses on ensuring all psychotropic medications have appropriate indication. **Plan to monitor performance to maintain compliance:** Indication for psychotropic medications will be reviewed in our monthly behavior meeting for accuracy. If any compliance trends are identified, they will be reviewed in QAPI meeting. **Date of Compliance: 9/12/22**	

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F 0812 SS=D 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 standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food in the kitchen and dry storage was dated with open and expiration dates, resident and employee food was identified, labeled, dated, and not kept in the kitchen refrigerator, hairnets were worn in all the kitchens for 4 of 6 home buildings; and failed to ensure staff in 2 of 6 home buildings performed hand hygiene before assisting with residents' meals. Findings include: 1. During a kitchen tour of Home 5, with Home Care Specialist (HCS) 5, the following was	F 0812	The Restoracy of Whitestown Plan of Correction- F812 **Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements	09/12/2022

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	observed: On 8/1/22 at 11:10 a.m., a plastic bag of whipped cream and head of lettuce were observed unopened and undated. Two eggs were observed in a plastic bowl with no expiration date. A package of 3 hamburger buns were undated and were thrown out. In dry storage, long grain wild rice, muffin mix, Quaker oats, and instant potatoes were observed open, with no open or expiration dating. In the chest freezer, an unopened bag of French fries and a breaded chicken container were observed with no dating. HCS 5 was observed to write dates on packages as the tour continued. On 8/1/22 at 11:19 a.m., Certified Nursing Aid (CNA) 6's food was observed in the kitchen refrigerator. It was in a plastic bag with very loose foil on it, the food was observed. On 8/1/22 at 12:46 p.m., HCS 5 indicated he had no plan to cook food for his building and another building today, but HCS 7 called and asked him to do it. 2. During a kitchen tour of Home 6, with HCS 7, the following was observed: On 8/1/22 at 11:51 a.m., the eggs were observed undated. A single serving bowl of covered cheerios was undated. Two packages of hamburger buns were observed undated. An opened container of Quaker oats was observed without an open date. HCS 7 dropped the lid on the floor, did not put it back on the Quaker oats. He left the Quaker oats on the shelf and opened to the air. The chest freezer food items were observed. The frozen pork, hamburger patties, and chicken breasts were observed without open and expiration dates. A container of cake, with one		established by the state and federal law. **Alleged deficiency:** Failure to ensure food in the kitchen and dry storage was dated with open and expiration dates, resident's and employee food was identified, labeled, dated and not kept in kitchen refrigerator, hairnets were worn in all kitchens, staff performed hand hygiene before assisting with resident meals. **Corrective Action for deficient:** All dietary staff will be educated on ensuring food in the kitchen and dry storage is dated with open and expiration dates, including items out of the original container. All dietary staff will be educated on ensuring food is secure and properly covered. All staff will be educated on appropriate storage of employee meals in designated refrigerator. All Staff will be educated on appropriate storage of resident food in kitchen refrigerator including labels and dates. All staff will now be required to wear a head/hair covering, scrub caps or hair nets, as part of their uniform. All male staff with facial hair will be educated on the requirement for beard covers when in the kitchen area. All staff will be educated on proper donning and doffing of gloves and handwashing with competency evaluations. All staff will be educated on our	

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	slice remaining, had no open or expiration date on it. HCS 7 wrote dates on items throughout the tour. During a random observation of Home 6's kitchen, the following was observed: On 8/3/22 at 3:35 p.m., HCS 13 was observed washing her hands in the kitchen. She turned off the water with her bare hands and dried her hands on her pants. She was not wearing a hair net. HCS 14 was observed with no hair net. She was from Home 5 and was getting food from Home 6 to take to Home 5, ham and peas. Thick ham slices were observed laid out on a metal oven pan. Both HCS' indicated they should have been wearing hairnets in the kitchen. HCS 14 indicated it was very important to wear hairnets in the kitchen. On 8/3/22 at 3:52 p.m., Qualified Medication Aide (QMA) 12 was observed to walk into the kitchen to get 2 small applesauce containers for the medication cart. She indicated she should have worn a hairnet to enter the kitchen. 3. During lunch observation of Home 6 on 8/1/22 from 12:00 p.m. to 12:38 p.m., the following was observed: On 8/1/22 at 12:00 p.m., Home Care Specialist (HCS) 7 was observed bring in hot, prepared food from Home 5. He indicated he did not have time to cook because he was cleaning his kitchen. At 12:05 p.m., HCS 7 was observed going in pantry, scratched his nose with his finger under his mask, and removed the scoop from a large can of vanilla pudding. He put the remainder of the pudding in plastic container and dated it. Throughout this observation he did not wash or		fingernail policy. All nursing staff will be educated on our policy and procedures for assisting residents with meals. **Measures put into place or systemic changes:** During orientation, all oncoming dietary staff will be educated on appropriate food storage with labels and dates. All oncoming staff will be educated on employee and resident food storage, wearing of head/hair covers as part as their uniforms, male staff educated on need for beard covering while in food prep area, proper donning and doffing of gloves, handwashing, and nail policy. All oncoming nursing staff will be educated on assisting residents with meals. This education will be reviewed at least annually. **Plan to monitor performance to maintain compliance**: Dietary manager or designee will audit all refrigerator and dry storage for appropriate labeling, dating, ensuring food is secure and properly covered, ensuring employee food is not in kitchen refrigerator and resident food is stored properly with labels and dates for minimum of 5 times a week x 1 month, then 3 times a week x 1 month, then weekly x 4 months until 100% of compliance is maintained. Dietary manager or designee will audit to ensure all	

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	gel his hands. He got a container of ice and took it to Home 5. He was observed returning from Home 5, touched the outside door with his bare hands. He did not hand wash but put on disposable gloves. He removed drink pitchers from the refrigerator. He was observed opening several cabinet doors with the gloves still on his hands. Then, he removed dinner plate from the cabinet. At 12:14 p.m., HCS 7 was observed deboning meat, he removed his gloves and turned on the heat under a pan on the stove. He did not wash his hands or put on new gloves. At 12:18 p.m., HCS 7 was observed to wash his hands after he removed his gloves. He partially dried his hands with paper towels, turned off the faucet with the paper towel, then finished drying his hands with the soiled paper towel. He was observed to do this procedure for hand washing on several occasions: 12:24 p.m., 12:25 p.m., after touching the microwave handle to retrieve an unidentified resident's lunch, 12:29 p.m., 12:33 p.m., and 12:38 p.m. At 12:21 p.m., HCS 7 was observed to pull open the microwave by the soiled handle with his gloved hands. He did not change gloves and wash him hands before preparing the next resident's food. At 12:33 p.m., HCS 7 was observed to drop meat on the kitchen counter. He used the meat tongs to pick it up off the counter. He used the same, soiled meat tongs at serve meat to 2 additional residents. At 12:35 p.m., HCS 7 was observed to put on new disposable gloves. He opened the microwave by the soiled handle and prepared a resident's lunch		staff have their hair coverings in place, and male staff with facial hair have a beard covering in the kitchen area for minimum of 5 times a week x 1 month, then 3 times a week x 1 month, then weekly x 4 months until 100% of compliance is maintained. Dietary manager or designee will perform random competency evaluations for dietary staff on donning and doffing gloves with handwashing at the rate of three evaluations 3 times a week x 1 month, three evaluations weekly x 2-months, one evaluation weekly x 3 month until 100% compliance is maintained. Director of Nursing, Assistant Director of Nursing, or designee will perform competency evaluations for nursing staff on handwashing, donning and doffing gloves, and assisting residents with meals while ensuring these staff members are following our fingernail policy. Two random competencies will be performed twice a week x 1 month, then two competencies monthly x 2 moths, then two competencies monthly x 3 months until 100% compliance is maintained. If any compliance trends are identified, they will be reviewed in QAPI meeting. **Date of Compliance: 9/12/22**	

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	plate. He used the dirty tongs to pull meat from the metal pan on the stove to debone it. 4. During lunch observations in Home 5 the following was observed: On 8/1/22 at 12:44 p.m., Certified Nursing Aide (CNA) 6 was observed assisting Resident 24 with eating. CNA 6 had very long, and polished artificial nails. After a few minutes, she was observed getting up from the table. When she returned, she touched the chair two times, but then turned and assisted Resident 24 with eating again. She did not wash her hands. She got up again while assisting the same resident with eating and removed 2 other resident's completed lunch plates. She touched a chair with her bare hands. She did not hand wash. She stood while she assisted Resident 20 and 24 with drinking, On 8/3/22 at 3:50 p.m., HCS 14 was observed rinsing off her disposable gloves before throwing them away. She did not wash her hands after removing the gloves. Then, she wrapped an unidentified food item in cellophane.5. On 8/1/22 at 10:03 a.m., during the observation and initial tour of the kitchen, in Home 4, with Home Care Specialist (HCS) 22, the refrigerator had 2 round clear containers of left-over Chinese food, undated or labeled with a name, a sunflower lunch bag the refrigerator without a date or name, a large fast food cup without a date or name, and a previously frozen boxed dinner in the bottom of the refrigerator, undated or labeled with a name. A Ziploc bag of hotdogs, open dated 7/29, was standing open. On 8/1/22 at 10:08 a.m., during an interview, HCS 22 indicated the lunch bag, fast food cup and boxed dinner all belonged to employees. The			

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	left-over Chinese food was a Resident's from the day before. They should all have been labeled with name and dates. On 8/1/22 at 10:11 a.m., Certified Nurse Aids (CNA) 27 and 28 were both observed behind the counter, in the kitchen prep area without hair nets. On 8/1/22 at 10:16 a.m., during an observation of the freezer, in the Home 4 pantry, with HCS 22, a large Ziploc bag of frozen hamburger patties was observed standing open, unsealed. On 8/1/22 at 10:20 a.m., during an interview, HCS 22 indicated the bag should have been sealed shut. On 8/01/22 at 10:11 a.m., in Home 4, CNA 27 and CNA 28 were both observed behind the kitchen counter, in the prep area, without hair nets. 6. On 8/2/22 09:14 a.m., during a random observation of Home 3, CNA 25 and 26 were observed in the kitchen at the back counter, prep area without hair nets. On 8/2/22 at 9:14 a.m., during an observation and interview, the HCS from Kitchen 1 was observed as he entered Home 3. HCS 19 indicated the two aids (who were both in the kitchen at that time) should have had on hair nets per policy. On 8/1/22 at 12:56 p.m., Licensed Practical Nurse (LPN) 23 was observed as she took a completed tray of food from a resident room to the kitchen. She entered left side, walked to the back, and put the tray on the counter. She was not wearing a hair net. 7. On 8/1/22 at 1:03 p.m., CNA 26 was observed as			

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	she assisted Resident 32 to eat. When she finished the meal, CNA 26 took the dishes to the left side of kitchen and walked through the prep area. She then washed her hands at the sink. She was not wearing a hair net. CNA 25 then entered the kitchen with soiled dishes without a hair net. On 8/2/22 at 3:17 p.m., the Director of Nursing (DON) indicated the food items in the Homes should have been dated when opened and should have had an expiration date. A current policy, titled, "Handwashing/Hand Hygiene," with no date, was provided by the DON on 8/2/22 at 3:54 p.m. A review of the policy indicated, " ...All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors...." On 8/3/22 at 9:05 a.m., the Director of Nursing (DON) provided a current policy, dated 5/27/20, titled, "Employee Meals." This policy indicated, "...The shift staff may bring in personal food. Employee must label personal food items/containers being placed in the designated refrigerator with your name and date...." On 8/3/22 at 9:05 a.m., the Director of Nursing (DON) provided a current policy, dated 5/27/20, titled, "Resident Food Policy." This Policy indicated, "...When food item is brought in by outside source and not immediately consumed by resident, it will be labeled with resident name and dated with date opened by staff member, if applicable...If food item requires refrigeration, family may notify staff member. Staff member will label it and place it in the refrigerator in the kitchen with appropriate label...."			

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	3.1-21(i)(2) 3.1-21(i)(3)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;			

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	(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure appropriate PPE (personal protective equipment) was utilized correctly during resident care in a COVID-19 positive (Red) Room for 1 of 1 resident COVID-19	F 0880	The Restoracy of Whitestown Plan of Correction- F880 **Disclaimer:**	09/12/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	positive (Resident 54) and appropriate PPE in resident areas for 2 of 6 home buildings (Residents 7, 219, 16, 32, 28, and 30). The facility failed to ensure hand washing was completed at appropriately during medication administration for 3 of 3 random residents observed during medication administration (Resident 36, 48, and 5). Findings include: 1. On 8/1/22 at 10:00 a.m., upon initial entrance into Home 3, there was a sign posted on the front door which indicated there was a COVID-19 positive resident in the house and gave instructions to keep masks pulled up and on at all times. During an interview on 8/1/22 at 10:02 a.m., the Staffing Coordinator indicated there was one COVID-19 positive resident in Home 3. Resident 54 had tested positive on 7/31/22 after a potential exposure from a positive staff member and was in droplet isolation. In Home 3, on 8/1/22 at 10:13 a.m., Licensed Practical Nurse (LPN) 23 was observed as she exited Resident 7's room. Her surgical mask was pulled down below her chin. She pulled her mask back up at the nurses' cart. In Home 2, on 8/1/22 at 11:07 a.m., a visiting lab technician approached a room with a yellow stop sign which indicated droplet isolation precautions. Certified Nursing Assistant (CNA) 6 informed the lab tech to place on PPE as a precaution as the resident was in isolation due to being a new admission. The Lab tech donned all the appropriate PPE except she placed a new N95 face mask overtop of the surgical mask, which was already in place, therefore a proper seal was not		This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure appropriate PPE was utilized correctly during resident in a Covid-19 positive room and appropriate PPE in resident areas. Failed to ensure hand washing was completed appropriately during medication administration. **Corrective Action for resident(s) found to have deficient:** All staff will attend inservices regarding infection control specifically to proper wearing of mask, proper donning and doffing of PPE with skilled competency evaluations. License nurses and qualified medication administrators will be educated on proper use of PPE during covid testing and best practices related to infection control during mediation administration with skilled competency evaluations. **Measures put into place or systemic changes:** All oncoming staff will be educated on infection	

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	155858	A. BUILDING 00 B. WING	08/05/2022

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	created. In Home 2, on 8/1/22 at 11:24 a.m., the lab tech who had completed a lab draw in a yellow isolation room, entered Resident 219's room (a green room) and completed a blood draw. In Home 2, on 8/1/22 at 12:45 p.m., LPN 35 was observed at the nurses' cart which was located in the central common area by the dining room. A Physical Therapist (PT) 36 approached her cart and requested a second step PPD (tuberculosis skin test) and a COVID-19 test. After completing the PPD skin test, LPN 35 placed on gloves and performed a nasal swab on PT 36. She did not don a face shield, or any additional PPE. There were two unidentified residents at the dining room table. 2. In Home 3, on 8/2/22 at 10:13 a.m., LPN 23 was observed in Resident 16's room. Her mask was pulled down below her chin as she and the resident spoke. In Home 3, on 8/2/22 at 2:39 p.m., a pair of goggles was observed on the PPE bin outside of Resident 54's room. At that time, LPN 23 indicated CNA 26 was in Resident 54's room providing resident care. When asked if the CNA's PPE could be observed, LPN 23 knocked on and cracked open Resident 54's door. CNA 26 was not observed to have eye protection in place at that time. During an interview on 8/2/22 at 2:40 p.m., LPN 23 indicated staff were supposed to wear eye protection in droplet precaution isolation rooms. 3. In Home 3, on 8/3/22 at 9:45 a.m., the Staffing Coordinator approached Resident 54's room. He indicated he needed to hand off supplies to the		control specifically to proper wearing of mask, proper donning and doffing of PPE with skilled competency at orientation. All oncoming license nurses and qualified medication administrators will be educated on proper use of PPE during covid testing and best practices related to infection control during mediation administration with skilled competency evaluations, during orientation. This education will be reviewed at least annually. **Plan to monitor performance to maintain compliance:** Director of Nursing, Assistant Director of Nursing or designee will perform three random competency evaluation once a week x 1 month, then one a week x 2 months, then one monthly x 3 months until 100% of compliance is maintained. If any compliance trends are identified, they will be reviewed in QAPI meetings. Additional In-servicing: All staff have been educated by the Director of Nursing or Assistant Director of Nursing regarding Proper techniques for hand hygiene, PPE protocols and guidelines, isolation protocols and procedures, and Covid-19 zones. All nurses and QMAs have been educated by the Director of Nursing or Assistant Director of Nursing regarding infection control	

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	nurse who was proving resident care at that time. When asked if the nurses' PPE could be observed, he knocked on and cracked open the door to give LPN 23 supplies. At that time, LPN 23 was observed wearing an N95 face mask, but the bottom strap hung lose below her chin. When LPN 23 exited Resident 54's room a surgical mask was observed under her N95 so that a proper seal was not created. Additionally, she removed the N95 mask, which had been used in the COVID-19 positive room and discarded it in the open trash can at the kitchen counter. Residents 32, 28 and 30 were seated in the dining room near the trash can. During an interview on 8/3/22 at 11:03 a.m., the above observations were shared with the DON. She indicated staff should always keep their masks up in place, especially in house 3 since there was a COVID-19 positive resident. Staff should also not perform COVID-19 nasal swabs in resident common areas, they could be performed in the front office building or in House medication rooms. When performing the COVID-19 test swabs, staff should wear eye protection in case of splash. PPE should be doffed in the isolation rooms and left in trash cans inside the rooms until it could be safely removed. Finally, it was expected that resident care or services should be performed in green rooms first, then yellow, and red rooms last to reduce the chance of spreading COVID. On 8/4/22 at 9:07 a.m., the DON provided a Copy of current facility competency validation titled, "Personal Protective Equipment (PPE) Competency Validation." The Validation for donning and doffing PPE required, while donning a mask/respirator staff should secure ties/elastic bands at middle of the head and neck, and goggles should be in place. When doffing, staff		policies and procedures regarding medication administration. In-person and/or virtual training for all staff is on-going by the QSource Infection Preventionist Consultant to improve staff education retention due to repetitive nature. Additions to Orientation: All oncoming staff will receive departmental specific infection control guidelines for each department within the facility, in addition to the standard infection control training. Additional Monitoring: The Director of Nursing, Assistant Director of Nursing, or designee will perform staff evaluations for appropriate hand washing throughout the facility, including during medication administration and before/after resident care. Daily monitoring 5 times a week x 6 weeks, twice a week x 4 weeks, weekly monitoring x 4 weeks, monthly monitoring x 2 months. The Director of Nursing, Assistant Director of Nursing, or designee will perform staff evaluations for appropriate PPE donning and doffing and PPE utilization. Daily monitoring 5 times a week x 6 weeks, twice a week x 4 weeks, monthly monitoring x 4 weeks. The Director of Nursing, Assistant Director of Nursing, or designee will perform nurse and/or QMA observation and monitoring of	

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	should discard PPE in a waste container. 4. During a random medication administration on 8/3/22 at 4:06 p.m., Qualified Medication Aide (QMA) 12 was observed popping pills from the blister package into her hands for Resident 36. She put them into the medication cup and Resident 36 was observed to swallow them. a. carvedilol (antihypertension) 12.5 milligrams (mg) b. levetiracetam (anticonvulsant) 140 mg On 8/3/22 at 4:09 p.m., QMA 12 did not wash or gel her hands before she prepared medications for Resident 48. She dropped the pills into her hand and put them into the medication cup. a. cephalexin (antibiotic) 250 mg, b. melatonin (hormone) 3 mg, c. metformin (antidiabetic) 500 mg d. risperidone (antipsychotic) e. Tylenol Arthritis Pain ER (Extended Release) 650 mg She provided the medication to Resident 48 in the dining room. Two unidentified residents were sitting with her. Resident 36 touched her hand. On 8/3/22 at 4:22 p.m., QMA 12 indicated since Resident 36 touched her hand, she needed to hand wash. She turned the water faucet off with her bare hands and dried with a paper towel. On 8/3/22 at 4:25 p.m., QMA 12 provided Resident 5 with an unidentified medication. She was observed to wash her hands afterward. She turned the water faucet off with her bare hands and dried with a paper towel. During an interview, on 8/3/22 at 4:23 p.m., QMA 12 indicated she should not have put pills into her hand, then place them in the medication cup them in the medication cup and she should have		medication administration techniques. Daily monitoring 5 times a week x 6 weeks, twice a week x 4 weeks, weekly monitoring x 4 weeks, monthly monitoring x 2 months. All monitoring then will be random on a quarterly basis. All audits will be reviewed at QAPI meeting as well as by QSource Infection Preventionist Consultant on a monthly basis to track and trend progression on compliance and adjust DPOC as needed throughout the project according to any deficiencies identified. Return Demonstrations: Hand Hygiene techniques and Donning and Doffing of PPE competencies have been conducted with all staff and will be conducted on an annual basis or as needed if deficiencies are present as a result of quarterly monitoring. **Date of Compliance: 9/12/22**	

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	washed her hands between each resident. During an interview, on 8/2/22 at 3:11 p.m., the Director of Nursing (DON) indicated the staff should have washed their hands for 20 seconds, dried them with paper towel, then got a new paper towel to turn off the water after their hands are dried. A current policy, titled, "Handwashing/Hand Hygiene," with no date, was provided by the DON on 8/2/22 at 3:54 p.m. A review of the policy indicated, " ...All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors ... A current policy, titled, "Medication Administration General Guidelines Policy," dated 5/27/20, was provided by the DON on 8/4/22 at 9:40 a.m. A review of the policy indicated, " ...The facility will provide appropriate care and services to manage the resident's medication regimen to avoid unnecessary medications and minimize negative outcomes ...Alcohol gel may be used between resident when passing oral medications ...." 3.1-18(b)(1)			
F 9999 Bldg. 00	3.1-14 Personnel (b) A facility must not use any individual working in the facility as a nurse aide for more than four (4) months on a full-time, part-time, temporary, per diem, or other basis unless that individual: (1) is competent to provide nursing and	F 9999	The Restoracy of Whitestown Plan of Correction- F9999 **Disclaimer:** This Plan of Correction constitutes this facility's written allegation of	09/12/2022

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	nursing-related services; and (2) has completed a: (A) training and competency evaluation program; or (B) competency evaluation program; approved by the division. (c) Each nurse aide who is hired to work in a facility shall have successfully completed a nurse aide training program approved by the division or shall enroll in the first available approved training program scheduled to commence within sixty (60) days of the date of the nurse aide's employment. The program may be established by the facility, an organization, or an institution. The training program shall consist of at least the following: (1) Thirty (30) hours of classroom instruction within one hundred twenty (120) days of employment. At least sixteen (16) of those hours shall be in the following areas prior to any direct contact with a resident: (A) Communication and interpersonal skills. (B) Infection control. (C) Safety/emergency procedures, including the Heimlich maneuver. (D) Promoting residents' independence. (E) Respecting residents' rights. This rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure 2 of 4 Certified Nursing Assistants (CNAs) did not work without the appropriate license. Findings include: On 8/5/22 at 12:10 p.m., ten randomly selected employee records were reviewed. Four staff were		compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or the that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to ensure 2 of 4 nursing assistance did not work without the appropriate license. **Corrective Action for staff member(s) found to have deficient:** Staff members #31 and #32 were removed from the scheduled. **Identify other staff having same potential deficient:** Staff members that relocate to Indiana from another state. Staff members that have completed their CNA training course but have not taken their certification test. **Measures put into place or systemic changes:** An audit was conducted on all employees and no other employees found to have this deficiency. All oncoming staff that have relocated to Indiana or have completed their CNA training course but have not taken their certification test will be placed on a newly developed tracking form to ensure they do	

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	found without licenses. Certified Nursing Assistant (CNA) 31 with a start date of 7/13/21, CNA 32 with a start date of 3/22/22, CNA 33 with a start date of 5/16/22, and CNA 34 with a start date of 2/26/22. During an interview on 8/5/22 at 1:10 p.m., the Executive Director (ED) indicated Certified Nursing Assistant (CNA) 31 was hired on 7/13/21. She had worked in the facility for over a year with an out of state license but had not completed her Indiana test within the 120-day timeframe. Additionally, CNA 32 was from out of state and had worked 130 days past the deadline. The ED found that CNA 32 was out of compliance on 8/4/22 and took the CNA off the schedule, however they had already worked in Home 5 with 12 residents on July 25, 26, 27, 28, 29 and August 1, 2, and 3, 2022. During an interview on 8/5/22 at 3:27 p.m., the ED provided the following dates that CNA 31 had worked in Home 1: July 2, 3, 9, 10, 16, 17, 23, 24, 30, and 31, 2022. The ED indicated she was a weekend option CNA and worked weekends.		not work past their allowed 120 days without transferring their CNA license or passing the certification test. **Plan to monitor performance to maintain compliance**: The Executive Director or designee will perform a monthly audit of tracking form to ensure compliance x 6 months. If any compliance trends are identified, we will review in QAPI meetings. **Date of Compliance: 9/12/22**	