STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155236	A. BUILDING 00 B. WING	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AVON HEALTH & REHABILITATION CENTER	4171 FOREST POINTE CIRCLE AVON, IN 46123

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00381444, IN00384815, and IN00386296. This visit included a State Residential Licensure Survey. Complaint IN00381444 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00384815- Unsubstantiated due to lack of evidence. Complaint IN00386296 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: August 15, 16, 17, 18, 19, and 22, 2022. Facility number: 000141 Provider number: 155236 AIM number: 100283860 Census Bed Type: SNF/NF: 118 SNF: 2 Residential: 26 Total: 146 Census Payor Type: Medicare: 14 Medicaid: 76 Other: 30 Total: 120 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	

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

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	Quality review completed on September 1, 2022.			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically			

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	update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on observation, interview, and record review, the facility failed to ensure a resident's (Resident 21) physician was notified for a change in condition related to increased pain and limited range of motion, and failed to notify the physician after it had been noted she spit out medication for 1 of 2 residents reviewed for pain. Findings include: On 8/15/22 at 10:30 a.m., Resident 21 was observed as she laid in bed. She laid on her right side, and her knees were pulled up towards her chest, almost in a fetal position. She grimaced her face and indicated she hurt all over. During a confidential interview, it was indicated Resident 21 was recently moved from the secured memory care unit, to the far back of the 500-Long Term Care Hall. It was right by an exit door, and not a day after she moved, Resident 21 was agitated and attempted to get out of the door. Over the weekend she remained restless and had a fall. She had been in bed ever since. On 8/16/22 at 2:18 p.m., Certified Nursing	F 0580	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 21's physician was made aware of her change in pain and range of motion. Her pain is being treated and she will be re-evaluated to ensure her post-fall status is resolving. He was also made aware that she spit out some unidentifiable medication. No new orders were received. 2. All residents status post-fall have the potential to be affected and all residents that have fallen in the last 7 days were reviewed to ensure and change in status is communicated to his/her physician. All residents receiving medications have the potential to be affected. See below for corrective actions. 3. The policies for Pain Evaluation and Physician/Clinician/Family/Responsible Party Notification for Change in Condition were reviewed	09/16/2022

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	Assistant (CNA) 20 was observed as she passed ice water at Resident 21's room. At this time she indicated Resident 21 was new to the hall, she moved from the memory care unit. CNA 20 had been off over the weekend, but when she returned to work that morning, Resident 21 was not her normal self. Usually Resident 21 could independently transfer, and liked to get out of bed, but now she stayed in bed and complained of pain. CNA 20 indicated her pain was localized to the left hip area. During an interview on 8/16/22 at 3:02 p.m., Registered Nurse (RN) 21 indicated yesterday the CNA had informed him that Resident 21 was complaining of pain. When he assessed her, it appeared she had some increased pain which she showed in her face and increased limited range of motion in her lower extremities. She was still on fall follow up from her fall over the weekend, so he had documented his assessment in the fall follow up assessment but had not called the Physician or DON at that time. He had not been down to check on her so far, as she had been sleeping when he arrived on his shift. On 8/16/22 at 3:15 p.m., RN 21 was observed as he went to assess Resident 21. She was pleasant and cooperative as he moved her arms and hands. However, when he attempted to have Resident 21 straighten her legs, she began to cry out in pain. He stopped and indicated it was similar to her reaction yesterday. When he attempted range of motion on her left leg a second time, Resident 21 cried out, "Ow! Get off of me!" RN 21 indicated he would the let Nurse Practitioner know and see if she would order an x-ray. On 8/16/22 at 3:57 p.m., a Mobil x-ray technician indicated he was able to complete 2 views of		and no changes were indicated. Licensed and non-licensed staff were re-educated on these policies. The DON or her designee will review 5 falls weekly for 6 weeks and until 100% compliance is achieved, then 5 per month for 6 months and until 100% compliance is maintained to ensure proper notifications are made as indicated. The DON or her designee will observe 5 residents, varying days and shifts, for 6 weeks and until 100% compliance is achieved, then 5 per month for 6 months and until 100% compliance is maintained to ensure medication is consumed and MD notification made as indicated. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	Resident 21's left hip. It took longer than usual, because she was in a great deal of pain, and it was difficult to get her positioned. During an interview on 8/16/22 at 4:13 p.m., the Director of Nursing (DON) indicated, RN 21 did note Resident had increased pain and limited range of motion on his post fall assessment, but should have notified the NP, or the DON at that time, so that an x-ray could have been ordered sooner. He had administered her pain medication at that time. On 8/17/22 at 9:00 a.m., the DON indicated, Resident 21's x-ray results had been received and were negative for fracture. On 8/17/22 at 9:39 a.m., Resident 21 was observed. She laid in bed with the head of her bed slightly elevated. Her eyes were open. There was a blue streaking stain observed on her bottom lip and upon closer observation, small white capsule/beads were observed stuck to her bottom lip. A partially dissolved blue capsule was observed on the resident's chest, with more small white capsule/beads coming out of it. There was a second circular white pill on her chest. At this time CNA 19 entered the room to check on Resident 21. The CNA was alerted to the pills, and she indicated, it appeared as if Resident 21 had spit them out. She wrapped the pills in a paper-towel and indicated she would let the nurse know. During a follow up interview on 8/19/22 at 11:41 a.m., CNA 19 indicated, she had taken the pills to the Unit Manager, During an interview on 8/19/22 at 11:43 a.m., Registered Nurse (RN) 4 indicated, CNA 19 had let			

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	her know Resident 21 spit out two pills and brought them to her. The pills had been administered by the QMA (qualified medication aid) on the medication cart, but were too disintegrated to identify, so she disposed of them in the sharps container. She had not notified the physician and did not know if the QMA had notified the physician either. During an interview on 8/19/22 at 11:47 a.m., the Assistant Director of Nursing (ADON) indicated, if medications were noted to have been spit out, the nurse should notify the physician to get an order to monitor the resident, especially if they were unable to determine what medications might have been missed and what side effects that might cause. On 8/16/22 at 4:30 p.m., Resident 21's medical record was reviewed. She had active diagnoses which included, but were not limited to, Alzheimer's disease with late onset, high blood pressure, atrial fibrillation, generalized anxiety and major depressive disorder. She had physicians order for the following scheduled daily medications: a. Aspirin (a blood thinning medication) 81 mg (milligrams) b. Buspirone 5 mg (an antianxiety medication) c. Diltiazem (a medication used to treat high blood pressure) 240 mg extended release d. Namenda (a medication used to treat dementia) 5 mg e. Tramadol (a narcotic pain medication used to treat pain) 50 mg f. Zoloft (an antidepressant medication) 100mg She had a current physician's order dated 1/27/22			

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	which indicated, "Resident requires secured memory care unit." Her census record indicated she had been moved to the Long-Term Care 500 hall on 8/9/22. A nursing progress note dated 8/10/22 at 1:38 p.m., (the day after her from the secured memory care unit) indicated, Resident 21 had become agitated and transferred out of her wheelchair and was walking in the hallway. She attempted to get out of the 500-hall back door and was hitting the window screaming "I want to go home," and "let me out," staff immediately assisted and attempted to redirect res, unsuccessful for several minutes until res became weak and needed to sit down in her wheelchair. A nursing progress note dated 8/14/222 at 4:38 p.m., indicated, Resident 21 had a fall. An IDT (interdisciplinary team) progress note dated 8/15/22 at 12:36 p.m., indicated Resident 21's fall was reviewed. She had been ambulating in the hallway, when she was noted to become weak and fell to the floor. An intervention was added for staff to offer Resident 21 assistance with ambulating prior to dinner. A post fall evaluation dated 8/15/22 at 5:00 p.m. indicated Resident 21 had limited right lower extremity limitations. The record lacked documentation the physician had been notified of the new limited range of motion. The record lacked documentation the physician had been notified of the two pills Resident 21 had spit out.			

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	On 8/16/22 at 4:30 p.m., the DON provided a current facility policy titled, "Pain Evaluation," dated 5/2012, revised 3/2020. The policy indicated, " ...Residents will have a pain evaluation completed upon admission, quarterly, and when the resident experiences new pain in a different location ... when completing the pain evaluation, the nurse will assess the resident pain level at the time the evaluation is completed ... nursing will document any complaints and sings/symptoms of pain in the progress notes as indicated ...." On 8/19/22 at 1:50 p.m., the DON provided a copy of current facility policy titled, "Physician/Clinician/Family/Responsible Party Notification for Change in Condition," dated 6/2014, revised 2/2022. The policy indicated, "To ensure that medical/psychological care problems are communicated to the attending physician/clinician and family/resident representative in a timely manner ... The facility must immediately inform the resident; consult with the resident's physician/clinician; an notify, consistent with his or her authority, the resident representative(s) when there is ... a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due adverse consequences, or to commence a new form of treatment ...." 3.1-5(a)(3)			
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.			

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	§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation and interview, the facility failed to properly dispose of of medication containers with confidential information identifying resident and physician orders on the label for 2 of 2 residents (Residents 44 and 71) with medication packages thrown into the medication cart trash can.	F 0583	The facility will ensure this requirement is met through the following corrective measures: 1. Residents 44 and 71's containers were removed from the trash and destroyed per policy. 2. All residents have the potential to be affected. Trash receptacles on the medication carts were	09/16/2022

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	Findings include: On 08/18/22 at 8:49 a.m., during a random medication storage observation of the 300 Hall medication cart, the trash can on the side of the cart had medication packaging visible with resident names on the container/package. An opened lidocaine (pain patch) patch label for Resident 71 indicated: "Lidocaine Patch 4 % Apply to lower back topically one time a day for pain. Pharmacy Active 12/2/2021 07:00 12/1/2021" An open bottle of omeprazole suspension, partially full, with a smeared label for Resident 44 indicated: "Omeprazole Suspension 2 MG/ML Give 20 ml by mouth one time a day for gastroesophageal reflux disease. Pharmacy Active 8/20/2022 07:00 8/19/2022" On 8/18/22 at 8:55 a.m., during an interview, Licensed Practical Nurse (LPN) 14 indicated the resident names should have been marked out in black marker before throwing medication packages in the trash to make them unidentifiable. She did not put them in the trash and did not know who did. LPN 14 had the medication cart keys and opened the cart to complete the medication storage observation. On 8/18/22 at 1:56 p.m., the Director of Nursing (DON) provided a current policy, dated as revised on 12/21, titled "Notice of Privacy Practices." This policy indicated "...Although your health record is the physical property of the nursing facility, the information in your record belongs to you...." On 8/22/22 at 11:00 a.m., the DON provided a current policy, dated as revised on 2/22, titled "Drug Disposition." This policy indicated		checked to ensure no other items with identifying labels were found and there were no more noted. See below for corrective measures. 3. The Drug Disposition policy was reviewed and no changes were indicated. Licensed staff will be re-educated on this policy. The DON or her designee will check medication cart trash receptacles 3 times weekly, varying days and shifts, for 6 weeks and until 100% compliance is achieved, then 5 times monthly for 6 months and until 100% compliance is maintained, to ensure medication packaging is disposed of per policy. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	"Non-unit dose drugs not qualifying for return to the issuing pharmacy and drugs left by residents discharged from the facility shall be destroyed...destroyed in the presence of two (2) licensed...persons witnessing the distribution/disposal of drugs must date and sign the drug disposition record..." 3.1-3(o)			
F 0607 SS=E Bldg. 00	483.12(b)(1)-(3) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, Based on interview and record review, the facility failed to follow their policy to ensure all newly hired employees had a criminal background check completed and reviewed before starting work at the facility for 1 of 5 randomly selected new hire employees reviewed for criminal background checks (Housekeeper 25). This deficient practice had the potential to effect 120 of 120 residents who resided in the facility. Findings include: On 8/15/22 during the entrance conference State Form 5440, employee records was provided to the	F 0607	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. 2. All residents have the potential to be affected. An audit was completed on all current staff who are minors to ensure criminal checks have been completed. 3. The Required Criminal History Checks for Minor Employees was reviewed and no changes were indicated. The new HR Director was educated on this policy. The	09/16/2022

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	Executive Director for completion. On 8/18/22 at 10:15 a.m., the employee record form and 5 new hire employee files, randomly selected, were reviewed. The file for Housekeeper 25, hired on 6/14/22, did not contain a criminal background check. On 8/18/22 at 1:25 p.m., the file was returned to the Business Office Manager (BOM) for verification. On 8/19/22 at 11:00 a.m., during an interview, the Director of Nursing (DON) indicated Housekeeper 25 was a minor.The facility's background check company did not do background checks for minors. The facility had sent her to a private fingerprint company to be fingerprinted for an Indiana State Police criminal record review. The company was supposed to mail the verification to the minor's parent's home address. The mother also worked at the facility and was known to them. The mother told the facility the report had not been received. Housekeeper 25 was not currently working any shifts at the facility because she was back in school, for the fall. The DON provided a (Name of Company) registration record for Housekeeper 25 to be finger printed on 8/19/22 at 4:10 p.m. She indicated they had requested she be re-finger printed since they had not received the first results. A printout of Housekeeper 25's time card indicated she had worked at the facility for 27 shifts between 6/14/22 and 8/18/22, for a total of 170.25 hours. On 8/22/22 at 12:03 p.m., the DON provided a current policy, dated as reviewed on 4/25/08, titled "Required Criminal History Checks for Minor Employees." This document indicated "To adhere to the State Department of Health's requirement as		HFA or her designee will audit all minor new hire files weekly for 6 weeks and until 100% compliance is achieved, then all minor new hires monthly for 6 months and until 100% compliance is maintained to ensure criminal checks on minors have been completed per policy. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	stated in IC 16-28-13 for obtaining criminal histories on all employees including minors. It is the policy of [Name of Corporation] to require that an Indiana State Police Limited Criminal History be obtained for minor employees prior to but no later than the first day of employment...." 3.1-28(a)			
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 record review and interview, the facility failed to ensure the Minimum Data Set assessment (MDS) was coded correctly for 1 of 2 residents (Resident 20) reviewed for Preadmission Screening and Resident Review (PASRR) . Findings include: On 8/15/22 at 9:28 a.m., the medical record was reviewed for Resident 20. The electronic record had a Preadmission Screening and Resident Review (PASRR) Level II document scanned into the file, it was dated November 16, 2021. This PASRR screen indicated Resident 20 had a serious mental illness with diagnoses of schizoeffective disorder, delusional disorder, and persistive depressive disorder. This document indicated "...Since this evaluation has determined that you have a PASRR Level II condition, if you admit to a Medicaid-certified nursing facility, or if you are currently in a Medicaid-certified nursing facility, the facility will need to document your PASRR condition in the	F 0641	The facility will ensure this requirement is met through the following corrective measures: 1. A MDS correction was completed/submitted for resident 20. 2. All residents with a Level II assessment have the potential to be affected and those MDS's were reviewed to ensure accuracy. 3. The RAI [Resident Assessment Instrument] Pages 3-1 and Z-5 is utilized in lieu of policy due to frequent updates. The MDS and Social Services staff were re-educated on this. The Social Services Director will audit 5 residents weekly for 6 weeks and until 100% compliance is achieved, then 5 residents per month for 6 months and until 100% compliance is maintained to ensure Level II's are coded accurately on the MDS. 4. The findings of these audits will be presented during the facility's	09/16/2022

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	Minimum Dataset (MDS) assessment record. The facility should mark yes for question A1500 on the MDS....Also your specific PASRR condition(s) should be checked in question A1510, "Level II Preadmission Screening and Resident Review (PASRR) Conditions...." Resident 20 was admitted to the facility on 5/5/22. The Admission Minimum Dataset (MDS) assessment indicated "No" for question 1500A "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?" Section 1510 did not have a check to indicate Resident 20 had any serious mental health conditions. On 8/17/22 at 2:01 p.m., during an interview with the Social Service Director (SSD) she indicated Resident 20 had a PASARR Level II. The resident had been admitted from another facility. They had started a PASRR Level I on her but she already had a PASRR II from the other facility and they were able to use it. She had spoke to the Minimum Dataset (MDS) Coordinator about the coding, because she did not do the coding in MDS. He indicated to her the Level II could only be coded on a comprehensive review. It had not been coded on the admission comprehensive and would have to be added to the annual when it was done. On 8/22/22 at 11:30 a.m., the Director of Nursing (DON) provided a current, undated policy, titled "Accurate coding peer the RAI [Resident Assessment Instrument] Pages 3-1 and Z-5..." This document indicated "...The goal of this chapter is to facilitate the accurate coding of the MDS...To facilitate accurate resident assessment...to the best of your knowledge, most accuraely reflects the resident's status..."		monthly QAPI meetings and the plan of action adjusted accordingly.	

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	3.1-31(i)			
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 a resident received necessary treatment medications prescribed by hospice services and failed to follow up in collaboration with the hospice company to ensure a resident who required hospice services received the plan of care as recommended on the hospice consult (Resident 37) for 1 of 1 residents reviewed for hospice services. Findings include: On 8/15/22 at 1:46 p.m., Resident 37 was observed up in a high backed wheel chair seated in front of the television in the common area. She appeared confused and disoriented. She did not converse. On 8/19/22 at 9:48 a.m., during an observation and interview, Resident 37 was observed up in a high back wheelchair in the common area, seated in front of the television. Her eyes were closed and her arms were folded across her lap. She did not carry a conversation but nodded and softly	F 0684	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 37 was not harmed. Hospice orders were transcribed into the EMR. Her plan of care was revised to include hospice services. 2. All residents receiving hospice services have the potential to be affected. Hospice charts were reviewed to ensure all pertinent information, including orders, have been transcribed into the EMR and the plans of care were reviewed/revised ensuring hospice services is addressed. 3. The policy Electronic Transcription of Hospice Orders was reviewed and no changes were indicated. Licensed nursing staff were re-educated on this policy. The DON or her designee will review 3 residents receiving hospice services weekly for 6	09/16/2022

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	responded yes and no. When asked how she was doing resident did not respond. When asked if she was having pain she shook her head and said no. On 8/18/22 at 1:47 p.m., the medical record was reviewed for Resident 37. The diagnoses included, but were not limited to, acute nuerologic metabolic encephalopathy (a progressive chemical deterioration of the brain) and cardiac (heart irregularities) arrythmias. A SBAR (situation, background, assessment, recommendation) note, dated 8/11/22 at 11:21 a.m., indicated a change in condition. " ... The resident's weight was 88 pounds per wheelchair scale ... She resided at the facility for long term care and had a history of dementia ... She had a "Do Not Resuscitate (DNR)" order ... Nursing observations, evaluation, and recommendations are: patient lost consciousness and 'fainted' on toilet after having an xxl bowel movement. Patient still able to respond to painful stimuli ... Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: daughter [Name] notified and does not want resident to be sent out to hospital, daughter contemplating hospice, daughter to let staff know upon deciding. If daughter decides not to do hospice Np wants labs drawn (cbc and bmp), UA [urinalysis] completed and vs q4." A Social Service progress note, dated 8/11/22 at 2:25 p.m., indicated, "Writer made aware of daughter's request for hospice services. Reviewed options and requested for referral be sent to [Name of Hospice Company]. Referral sent on this date." The physician's orders did not include an order		weeks and until 100% compliance is achieved, then 5 residents per month for 6 months and until 100% compliance is maintained to ensure hospice orders are transcribed into the EMR and that plans of care reflect hospice services. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	for hospice services. An order, dated 8/11/22, indicated do not send to the hospital, per daughter. There were no orders seen for hospice care medications or treatments. There was no care plan for hospice care. The most recent quarterly Minimum Data Set (MDS) assessment, dated 5/31/22, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3 which identified severe mental impairment. On 8/19/22 at 8:51 a.m., during an interview with the Social Service Director (SSD) she indicated the Nurse Practitioner let the nurses know to enter the physician order once the conversation had taken place with the family, for a hospice consult. On 8/19/22 at 8:55 a.m., during an interview, the Director of Nursing (DON) indicated there had been an order to evaluate for hospice, it was discontinued (from the physician order set) after the evaluation was completed. A printed copy of the discontinued electronic order, dated 8/11/22 at 2:37 p.m., indicated, "Hospice to evaluate and treat." On 8/19/22 at 8:56 a.m., Resident 37's hospice binder, at the nurses' station was reviewed. A hand written order set, on plain paper, was observed in the front of the binder. It indicated: 1. Admit to hospice effective 8/12/22 with diagnosis of senile regeneration with routine home care. 2. Morphine (pain medication) 20 mg/ml 0.25 ml po (by mouth) every 2 hours as needed. 3. Levsin (calming agent for stomach, intestine) 0.125 mg take 2 tablets every 4 hours as needed.			

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	4. Acetaminophen 650 mg supository give 1 QD (every day) as needed. 5. Biscadoyl 10 mg RR 1 supp QD as needed for constipation. 6. Discontinue Atrovastatin (cholesterol medication) and Thera vitamin. A review of Resident 37's electronic medical record and Medication Administration Record (MAR) did not indicate any of the above orders, current or discontinued. The record still contained active orders for atrovastatin and thera vitamins. On 8/19/22 at 9:20 a.m., during an interview, the DON indicated the hospice orders were usually given to a nurse, then they would make sure they were entered (into the physician order set of the electronic record). She would look at it. On 8/19/22 at 9:41 a.m., during a telephone interview, with the Hospice Executive Director of (Name of Hospice Company), she indicated we admitted her (Resident 37) on the 12th. The nurse, chaplain, social services and aid had all seen her. Paper copies of the chart documents were printed off weekly and brought out to the facility. The nurse doing the visit gave the orders to facility nurse. Per the visit notes and admission assessment, the hospice nurse consulted with Licensed Practical Nurse (LPN) 15, facility staff. The facility had access to view all the electronic hospice documents, and plan of care online. The printed copies would be placed in the binder on the next visit. On 8/19/22 at 9:58 a.m., during a second telephone interview with the Hospice Executive Director, she indicated Hospice Nurse 26 had completed Resident 37's hospice admission. She gave a written copy of the orders to Qualified Medication			

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	Assistant (QMA) 13 and told her there was a second copy in the binder. She took a copy with her. They always made 3 copies of their orders. On 8/22/22 at 11:00 a.m., the DON provided a current policy, dated as revised on 4/21, titled, "Electronic Transcription of Hospice Orders." This policy indicated, "To ensure the resident receives necessary treatment provided by hospice. Licensed Nurses from Hospice will enter the orders electronically into the resident's medical record. The orders will require a licensed facility nurse to confirm the order prior to being sent to the pharmacy. This will ensure the charge nurse for the resident is aware of any new orders received from hospice...." 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 resident, (Resident 41) with a history of falls and personal preference to prop her feet up, received a new bed, or had her broken bed repaired in a timely manner to prevent an accident when she slid out of bed for 1 of 7 residents reviewed for accidents, and failed to ensure medications were not left at the bedside of a resident, (Resident 104) who had	F 0689	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 41's bed was immediately replaced by the hospice company. Resident 104 took her medications as ordered. 2. All residents have the potential to be affected. Beds were	09/16/2022

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	poor vision for 1 of 7 residents reviewed for accidents. Findings include: 1. On 8/15/22 at 1:31 p.m., Resident 41 was observed as she laid in bed, and received two family visitors. Resident 41 was unable to answer questions. Her family member indicated, the facility always called to let them know about changes in her condition just like recently she [Resident 41] slid from her bed and had gotten a skin tear. During a confidential interview, it was indicated that Resident 41's bed had been broken for several weeks. The foot of her bed would not raise up to elevate her legs, like the resident preferred. Instead, her legs remained in a downward position which increased the likeliness that she could slide out of bed. At this time, it was demonstrated, by using the electric remote, the foot of Resident 41's bed would not raise when the button was pressed. It was indicated the family and several staff had been made aware of the issue. During an interview on 8/16/22 at 11:10 a.m., another visiting family member indicated he had witnessed Resident 41's last fall. He had been at the facility visiting his wife, who resided directly across the hall from Resident 41. He heard Resident 41's roommate calling for help, and when he got up to look, he saw that Resident 41 appeared to have slid from her bed. Her upper body was on the floor and her legs remained up in the bed. It had not taken long before staff got to her. During an interview on 8/16/22 at 11:20 a.m., the Maintenance Director indicated he was aware		checked to ensure they were in proper working order, including those provided by outside vendors. See below for additional corrective actions. 3. The Fall Investigation and Risk Evaluation policy and the Self-Administration of Medication policy was reviewed and no changes were indicated. Licensed and non-licensed nursing staff were educated on these policies. The DON or her designee will review 5 falls weekly for 6 weeks and until 100% compliance is achieved, then 5 per month for 6 months and until 100% compliance is maintained to ensure equipment is properly functioning. The DON or her designee will observe 5 residents, varying days and shifts, for 6 weeks and until 100% compliance is achieved, then 5 per month for 6 months and until 100% compliance is maintained to ensure medication is administered and not left at the bedside. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	Resident 41's bed was broken. The problem was the bed's actuator (a device on the bed used to lower and lift the bed into different positions). The company that manufactured the bed sent a replacement kit, however the kit did not fit her bed, so the whole bed would need to be replaced but "cooperate had not approved it yet." During a confidential interview it was indicated, Resident 41 did like to have her legs propped up. Since her bed was not working, she often propped her legs up on the visitor's chair beside her bed, or even sometimes on top of the overbed table if she could reach it. During a follow up interview on 8/16/22 at 1:45 p.m., Resident 41's visiting family member indicated, the bed had probably been broken for 2 months, maybe 7 weeks. She had spoken to the Maintenance Director and Social Services Director about it. Resident 41 liked to prop her feet up because she had always had low back pain, and that seemed to help alleviate some of her discomfort. Since the bed had been broken, she would sometimes prop her feet up on the chair beside her bed which caused her to lean, almost off the bed. On 8/16/22 at 4:00 p.m., Hospice staff were observed as the delivered a new bed to Resident 41. During an interview on 8/16/22 at 4:16 p.m., the Director of Nursing (DON) indicated she had not been notified that Resident 41's bed had been broken. If she had known sooner, she would have been able to contact Hospice to have her bed replaced as soon as needed. On 8/17/22 at 1:12 p.m., Resident 41's medical			

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	record was reviewed. She had active diagnoses which included, but were not limited to, Alzheimer's disease with late onset, dementia with behavioral disturbances, chronic pain and adjustment disorder. She was admitted to Hospice on 1/7/22. The most recent Minimum Data Set (MDS) assessment was a quarterly assessment dated 6/7/22. The MDS staff indicated she was severely cognitively impaired and required extensive to total assistance with all ADLS (activities of daily living). A nursing progress note, dated 8/14/22 at 11:22 a.m., indicated, " ...roommate alerted staff that resident was on the floor. Upon entering the room, PT [Resident 41] was laying on her back with the lower half of her legs still in the bed. PT was grabbing the back of her head, and her roommate said that she did hit her head when she fell ... assessed area, no bruising or bleeding noted in this moment. Writer obtained vitals and then lifted PT into bed. PT made comfortable, and pain medication administered. It was noted that PT had increased anxiety and restlessness today. PRN [as needed] Ativan [an antianxiety medication] administered per order ...." The physician was notified, and no new orders were given at that time. An IDT (interdisciplinary team) progress note, dated 8/15/22 at 1:28 p.m., met to discuss Resident 41's recent fall on 8/14/22, "...Summary of the fall: Resident was found lying on the floor in her room. Resident's roommate had called for assistance. Resident had previously been in her bed with her call light within reach but did not call for assistance prior to fall. Resident was not soiled			

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	and denied the need to toilet. Resident was noted to be wearing nonskid footwear. Resident was not able to state what she was attempting to do. Resident was noted to be restless prior to the fall. The floor was noted to be clean and dry. Root cause of fall: Resident was noted to be restless and appeared to have rolled out of bed. Intervention and care plan updated: Resident will have a medication adjustment related to increased restlessness...." A new skin and wound evaluation was opened 8/14/22 at 9:09 p.m. and indicated the presence of a new skin tear on Resident 41's right outer calf. The skin tear was linear and measured, 6.8 cm (centimeters) long, by 4.5 cm wide and was 1.9 cm deep. New orders were placed to " ...cleanse skin tear to right outer calf with wound cleanser pat dry apply hydrogel and foam every three days...." A Post-Fall note, dated 8/15/22 at 1:00 a.m., indicated the presence of a new skin tear on her leg, with no noted bleeding at that time. A Change of Condition Physician notification was placed on 8/14/22 at 10:21 p.m. and indicated the presence of a new skin tear. " ...Resident has a chair with wood arms beside her bed that she likes to put her legs on while she is lying in bed. She could have tore [torn] her fragile skin on the arm of the chair ...." On 8/22/22 at 11:00 a.m., the Administrator provided a copy of the most recent work orders placed on behalf of Resident 41. A work order of medium priority was placed on 8/9/22 at 11:52 a.m., which indicated, "Actuator had gone bad, and they are on back order." The work order was updated on 8/10/22 at 9:20 a.m. and indicated "set to completed."			

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	On 8/16/22 at 4:30 p.m., the DON provided a copy of current facility policy titled, "Fall Investigation and Risk Evaluation," dated 6/2012, revised 6/2022. The policy indicated, "It is the policy of this facility to provide an environment that is free from accident hazards over which the facility had control and provides supervision and assisted devices to prevent avoidable accidents ... "avoidable accident" means that an accident occurred because the facility failed to: identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices ...." 2. On 8/16/22 at 10:00 a.m., Resident 104 was observed as she laid in her bed. The head of her bed was elevated so that she sat upright. Both of her hands were observed to be contracted and at this time Resident 104 indicated she only had limited use of her left hand. Resident 104 had very slow, garbled speech and at times was difficult to understand. She indicated because of that it felt like many staff did not take the time to listen to everything she wanted to tell them and often rushed out of the room before completing the tasks she needed assistance with. On 8/18/22 at 9:11 a.m., Resident 104 was observed as she laid in bed with the head of her bed elevated so that she sat upright. Her overbed table was placed in front of her at this time, and there was a pill cup on the table with several unidentified pills and capsules. Resident 104 indicated the nurse left the pills for her to take on her won, but she wanted the nurse to stay so she could ask which pills she was getting at that time since she could not see them well. If she could not see them well, she was afraid she might miss one if it dropped.			

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	On 8/18/22 at 9:55 a.m., Resident 104's medical record was reviewed. She had active diagnoses which included, but were not limited to, injury of muscles and tendons of the rotator cuff of right shoulder, dysphagia (language disorder marked by deficiency in the generation of speech), hereditary motor and sensory neuropathy, and chronic pain. Her current/active physician's orders lacked documentation that Resident 104 could administer her medications by herself. The record lacked documentation of that a self-administration of medication assessment had been completed. An annual Minimum Data Set (MDS) assessment, dated 7/19/22, indicated Resident 104 was cognitively intact but required extensive to total assistance with all ADLS (activities of daily living). She had a comprehensive care plan, dated 10/6/21, indicated she had a communication deficit as evidence by dysphagia which resulted in slow, garbled speech. Interventions for this plan of care included, but was not limited to, "I will be given time to respond to prompts and questions." Another comprehensive care plan, dated 10/6/21, indicated Resident 104 had vision impairment and at times was unable to keep her eyes, or unable to open them effectively related to my motor and sensory neuropathy." Interventions for this plan of care included, but was not limited to, "...assist me with mobility and ADLs as needed...." During an interview on 8/18/22 at 9:28 a.m., the			

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	DON indicated she double checked Resident 104's record and there was not order or assessment for her to administer her own medications, her medications should not have been left at the bedside. On 8/18/22 at 12:00 p.m., the DON provided a copy of current facility policy titled, "Self-Administration of Medications," dated 3/2012 and revised 6/2021. The policy indicated, "...A resident may not be permitted to administer or retain medication in her/her room unless so ordered, in writing, by the attending physician/clinician ... Should the resident's attending physician/clinician permit the resident to administer his/her medication(s), the following conditions should apply, a. A self-administration of medication evaluation will be completed...." 3.1-45(a)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment			

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	and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview, and record review, the facility failed to ensure appropriate care and services for a resident who had received enteral feeding(s) for 1 of 1 resident reviewed for enteral nutrition (Resident 44). Findings include: Resident 44's clinical records were reviewed on August 12, 2022 at 2:30 p.m. Diagnoses included, but were not limited to anemia, gastroesophageal reflux disease, dementia, and malnutrition. The admission Minimum Data Set Assessment, dated May 27, 2022, indicated Resident 44 had moderate cognitive impairment, required extensive assistance with activities of daily living, and had a feeding tube due to coughing or choking during meals or when swallowing medications. An open ended physician order, dated May 23, 2022, indicated Jevity 1.2 (enteral nutrition) via peg tube at 30 mL/hour from 7:00 p.m. to 5:00 a.m. every shift. A physician order, dated August 01, 2022, indicated to hold (not administer) Jevity. Medication administration records, dated August 01 through August 17, 2022, indicated Jevity was held (not administered). Resident 44's care plan for enteral nutrition, dated June 08, 2022, indicated, "I will maintain my	F 0693	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 44 was not harmed as the feeding had been discontinued. The old bag and tubing were discarded. 2. All residents with an enteral feeding have the potential to be affected. Any resident with a tube feeding was checked to ensure the bag is labeled per policy. 3. The policy Gastric Tube Feeding via Continuous Pump was reviewed and no changes were indicated. Licensed nursing staff have been re-educated on this policy. The DON or her designee will audit 5 residents weekly (or all residents with a continuous enteral feeding if less than 5) for 6 weeks and until 100% compliance is achieved, then five residents per month (or all residents with a continuous enteral feeding if less than 5) for 6 months and until 100% compliance is maintained to ensure the administration bag is labeled per policy. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	09/16/2022

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	nutritional status utilizing my care plan interventions ... I will receive feeding(s) as ordered...." On August 17, 2022 at 1:06 p.m., Resident 44's room was observed to have 800 cubic centimeters (cc) of warm brown enteral nutrition inside of a non-labeled kangaroo pouch that had been hung from a pole. Connection tubing was present on the kangaroo pouch. During an interview, on August 17, 2022 at 2:15 p.m., the Director of Nursing indicated Resident 44's Jevity had not been being administered. The bag was hung, has been hanging since August 01, 2022, and had since been thrown away. On August 17, 2022 at 1:40 p.m.; Jevity 1.2 label was reviewed. The label indicated, "1000 cc bottle hand up to 48 hours after initial connection." On August 18, 2022 at 2:30 p.m.; the Director of Nursing provided a blank kangaroo label that is to be applied to enteral feedings. A review of the label indicated: Name Room Number Date Time Rate Formula Volume Per Day On August 18, 2022 at 9:30 a.m., the Director of Nursing provided a copy of the facility's current policy titled, "Gastric Tube Feeding via Gravity Bag," originally dated July 2012 and revised in April 2017 and again revised in September 2017. A review of the policy indicated, "Purpose: To			

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	provide nourishment to the resident who is unable to obtain nourishment orally...." The policy lacked documentation to label the kangaroo pouch to ensure hung formula within manufacture's recommendations. 3.1-44(a)(2)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to ensure a resident, (Resident 35) received post-dialysis assessments after returning from her appointments for 1 of 1 residents reviewed for dialysis. Findings include: On 8/15/22 at 11:02 a.m., Resident 35 was observed in her room. She sat in her wheelchair (WC) beside her bed and listened to an audio book. At this time, she indicated she did receive Dialysis on Tuesdays, Thursdays, and Saturdays, but she had missed a couple of days in the previous weeks and many times when she returned from her appointments, she was not given a post-Dialysis assessment. Usually, the nurse just took the form that came back with her to the nurse's station, and that was it. On 8/18/22 at 1:30 p.m. Resident 35 was observed in her room. She sat in her WC beside her bed and listened to an audio book. Resident 35 indicated	F 0698	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 35 was not harmed. 2. All residents on dialysis have the potential to be affected. See below for corrective actions. 3. The Dialysis policy was reviewed and no changes were indicated. Licensed nursing staff have been re-educated on this policy. The DON or her designee will audit 3 times weekly to ensure post-dialysis assessments are completed for 6 weeks and until 100% compliance is achieved, then weekly for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	09/16/2022

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	she returned from Dialysis earlier that afternoon. Her lunch tray had been left for her, so she started to eat. The nurse came down to give her medication but never did complete a post Dialysis assessment. They were supposed to take my vitals, bruit and thrill (the rumbling or swooshing sound of a dialysis fistula [an access made by joining an artery and vein which allows blood to travel through soft tubes to the dialysis machine]). On 8/17/22 at 11:35 a.m., Resident 35's medical record was reviewed. She had active diagnoses which included but were not limited to, end-stage renal disease with dependence on renal Dialysis. She had active physician's orders which included but were not limited to, an order dated 11/7/18 to check bruit and thrill of her Dialysis fistula every shift, and document Y=positive, N= negative. Resident 35's Medication Administration Record (MAR) was reviewed and revealed the above physician's order had not been checked off as completed for the following shifts: June 2, 3, 13, 14, 15, 16, 23, 24, 25 and 28, 2022. July 5, 13, 14, 15, 19, 21, 22, 25, 26, 27, 28, and 29, 2022. August 2, 3, 4, 5 and 11, 2022. Resident 35's MAR indicated "N=Negative" (no bruit/thrill detected) and lacked documentation that the physician had been notified on the following dates: June 7th night shift, and 11th and 12th day shift. July 4th, night shift. August 12th, evening shift. Resident 35 had a comprehensive care plan initially dated 11/7/18 and revised 5/6/2020. The			

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	care plan indicated Resident 35 had end-stage renal disease and required Dialysis. Interventions for this plan of care included, receiving medication as ordered, weights and vitals to be obtained as ordered and as needed, participation in Dialysis as scheduled, and a receiving her diet and supplements as ordered. The care plan lacked documentation of quarterly revision as required by the RAI (resident assessment instrument) and lacked person-centered specifications for Resident 35's transportation to and from her appointments, caring and/or monitoring of her fistula cite [including pre-post Dialysis assessments]. A nursing progress note, dated 6/8/21 at 2:30 p.m., indicated, "Resident returned from dialysis at approximately 1 p.m. ...." However, there was no corresponding Pre-Dialysis assessment. A nursing progress note, dated 5/6/21 at 1:23 p.m., indicated, "[Resident 35] returned from dialysis ...." There was no corresponding Pre-Dialysis assessment. A nursing progress note dated 2/2/21 at 1:15 p.m., indicated, "Resident out to dialysis this shift ..." There was no corresponding Pre-Dialysis assessment. From January 2022 to current August 2022 Pre/Post Dialysis assessments were reconciled revealed a total of 58 pre-Dialysis assessments had been completed, whereas only 14 were followed by post-Dialysis assessments. During an interview on 8/17/22 at 2:29 p.m., the Director of Nursing (DON) indicated there should be a post dialysis assessment completed by the facility nurse. Even though the resident comes			

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	back from the center with a communication form, the facility staff should be completing their own assessment. When the Resident comes back from the Dialysis center she would give the nurse the communication form, which would then go to Medical Records to get scanned in, but at that time it did not appear there was any indication (by way of nurses) signature or corresponding documentation that they had reviewed the communication forms. On 8/17/22 at 3:00 p.m., the DON provided a copy of current facility policy titled, "Dialysis," dated 5/2018, revised 4/2021. The policy indicated, " ...Residents receiving hemodialysis will receive appropriate monitoring and care from the facility and the dialysis provider in order to coordinate care ... monitoring of the dialysis fistula will be completed by the nurse assigned to the resident ... listen using a stethoscope for bruit and lightly palpate the fistula for the thrill once each shift. Document the presence or absence of the bruit and thrill on the treatment record each shift ... the physician and dialysis center will be notified of the bruit and thrill are no present ... A TLC pre-dialysis assessment will be completed before dialysis ... A TLC post-dialysis form will be completed after dialysis and compared to the pre-assessment; any abnormal findings will be reported to the physician .... Dialysis patients will have a coordinated care plan based on their plan and interventions...." CMS's (The Centers for Medicare & Medicaid Services) RAI Version 2.0, Chapter 2: The Assessment Schedule for the RAI" was reviewed and indicated, " ... Following the third Quarterly, and within a year of the Admission assessment, an Annual assessment is completed. This is a comprehensive assessment that requires a full			

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	MDS with RAPs and care plan review ... In conducting Quarterly assessments, facilities must also assess any additional items required for use by the State. Based on the Quarterly assessment, the resident's care plan is revised if necessary ...." 3.1-37(a)			
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 interviews and record reviews, the facility failed to ensure a resident (Resident 32) had the right to be informed of a reason for her move to a secured memory care unit, failed to accurately assess her before the move, and failed to implement less restrictive person-centered interventions before moving her to a secured memory care unit for 1 of 3 residents reviewed for transfer/discharge. Findings include: On 8/18/22 at 2:25 p.m., Resident 32's medical record was reviewed. She admitted to the facility in October of 2020 and resided in the main population until she was moved to the secured memory care unit on 8/9/22 which led to an unplanned discharge on 8/11/22. She had diagnoses which included but were not limited to cerebral infarction (stroke) due to thrombosis (blood clot which results in restricted blood flow) of right middle cerebral artery, hemiplegia (paralysis) affecting the left	F 0744	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 32 was reassessed for elopement risk and she is at risk. She has returned from her inpatient stay and is adjusting well to her room in memory care. She is involved in activities. Her plan of care has been reviewed and revised as indicated. Her responsible party gave verbal consent for admission to the Memory Care Unit and a signature will be obtained when next in the facility. 2. Any resident to be admitted to the Memory Care Unit has the potential to be affected. See below for corrective measures. 3. The Memory Care – Admission, Continued Stay, Transfer and Discharge policy was developed and the Memory Care	09/16/2022

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	nondominant side, vascular dementia, mood disorder due to known physiological condition with depressive features, pseudobulbar affect (Inappropriate involuntary laughing and crying due to a nervous system disorder), and generalized anxiety disorder. Her current, completed, and discontinued physician's orders were reviewed and lacked documentation that Resident 32 had a written order to reside on the secured memory care unit at any time during her residence. The most recent comprehensive assessment was an annual minimum data set (MDS) assessment dated 5/24/22. The MDS indicated Resident 32 was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 8 out of 15. There were no behaviors coded for the 7-day look back period which would include, but not be limited to, rejection of care. Resident 32's comprehensive care plans were reviewed and lacked documentation of concerns and/or complications related to wandering and/or making attempts to elope. A comprehensive care plan, dated 10/7/21, which indicated her specific choices: she enjoyed adult coloring books, word searches, watching TV, puzzle books, coffee/news, reading the daily chronicles, talking on the phone and spending time with family, she enjoyed people watching out her door and socializing with peers in the hallways and lounge areas. A comprehensive care plan, dated 10/13/21 and revised 1/16/22, which indicated Resident 32 had a cognitive deficit related to her CVA [stroke] and vascular dementia, but she continued to be alert		Director, DON, ADON, SS Director, SS Assistant, and Admissions staff have been educated on the new policy and Agreement Form. The HFA or her designee will review all potential admissions to Memory Care for 6 months and until 100% compliance is achieved, then twice monthly for 6 months and until 100% compliance is maintained to ensure assessment is accurate prior to admission to Memory Care, the reason for the move to Memory Care is explained/documented prior to admission to Memory Care, and that person-centered interventions that are less restrictive are attempted prior to moving to memory care. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	to her name, recognized family and familiar staff members, and that she was oriented to the facility. She presented with poor time orientation and short term recall. She had a comprehensive care plan, dated 2/24/22 and revised 8/15/22, which indicated Resident 32 had behavioral symptoms of hitting staff and peers, making negative statements towards staff and peers, refused care, and locked bathroom door related to a cognitive impairment and mood disorder. Resident 32 had a history of behavioral symptoms such as making negative statement about wanting to harm herself related to the passing of her roommate and diagnosis of major depression. Interventions for this plan of care included, but were not limited to, "Diversional activity such as watching my preferred television program, encouraging me to participate in communal activities, encouraging me to attend communal dining with me peers and talking on the phone with my family, encourage my family to participate with my behavior plan, reassure/comfort me when I need it to calm me down...." She did have a comprehensive care plan, dated 4/22/22, which indicated her overall mood was affected by pseudobulbar affect as evidence by her mood quickly changing and experiencing intense emptions which may be presented as sobbing without cause, then quickly changing to be laughing or talking without tearfulness. Interventions for this plan of care included, but were not limited to, " ...allow me to express my feeling, encourage me to discuss my feelings of anger and agitation and options of how to channel these feeling appropriately, encourage me to participate in activities, encourage me to use my support sources such as family, friends and			

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	church...." Resident 32 was seen on a regular and as needed basis by an outside agency, and her psychiatric progress notes were reviewed in the months leading up to her transfer to the secured memory care unit. A psychiatric progress note, dated 5/16/22, indicated Resident 32 was euthymic (a state of living without mood disturbances) with no acute concerns and moderate cognitive impairment. A behavioral follow-up progress note, dated 5/23/22 at 3:40 p.m., indicated on 5/21/22 Resident 32 had refused assistance with getting dressed then walked herself to the bathroom with unsteady gait and locked herself in the bathroom. When the CNA unlocked the bathroom door, Resident 32 swore at her. When she was redirected a few moments later, she allowed staff to help her. A corresponding Behavior Sheet was dated 5/21/22. A psychiatric progress note, dated 6/2/22, indicated Resident 32 was assessed in a common area as she participated in activities. Stated she was doing well and had no concerns at that time. She denied hallucinations, delusions, paranoia, illogical thought processes or worsening mood or depression. A psychiatric progress note, dated 6/20/22, indicated Resident 32 presented as depressed but became more responsive throughout the session. A psychiatric progress note, dated 6/23/22, indicated Resident 32 was assessed in her room where she was resting in bed. She was alert and pleasant, and stated she was doing well, and adjusting well to the introduction of Neudexta (a			

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	medication used to treat uncontrollable crying or laughing). Staff reported [Resident 32's] behaviors have stopped. A psychiatric progress note, dated 6/30/22, indicated Resident 32 was assessed in a common area sitting in a private section. She appeared tearful and when asked about her mood she began to cry. Staff reports she has been crying more lately. Introduced Neudexta to address these behaviors and plan to increase antidepressant. The most recent Risk Assessment was dated 7/5/22 and indicated Resident 32 was not at risk for elopement. The assessment indicated she did not have a diagnosis of dementia, did not demonstrate poor judgement or impaired safety awareness, did not have a history of wandering, did not verbalize wanting to leave the facility, did not search for spouse/family, and did not stand at locked doors waiting for someone to let her out. A psychiatric progress note, dated 7/14/22, indicated Resident 32 was assessed in the common area while she was waiting for morning exercise activities to begin. Staff reported Resident's moods have improved with less frequent episodes of tearfulness noted. A psychiatric progress note, dated 7/25/22, indicated Resident 32 was euthymic and was packing her belongings upon entry and stated, "I am packing up because my family is coming to get me." She noted she was looking forward to going home. Staff reported Resident 32 was not going home. The record lacked documentation than an updated elopement risk assessment had been completed on or after 7/25/22 related to the above psych noted related to Resident 32's delusion that			

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	she was going home. A psychiatric progress note, dated 7/28/22, indicated Resident 32 was assessed in the common area participating with group activities exercise and coffee-talk. She stated she was doing well. Staff reported she was stable and displayed no worsening mood or depression. Continued to be cooperative with care. Staff reported she sometimes did things to get attention. On 8/1/22 an initial psychiatric assessment was conducted by a new psychiatric practitioner as the facility had elected to switch to a new psychiatric consult group. This initial evaluation indicated Resident 32's chief complaint as, "I am very depressed." She was calm and cooperative. However, she was short and concrete in her answers. She admitted feeling sad, down and depressed, but denied feeling hopeless/helpless/worthless. She denied having episodes of crying although she was tearful throughout this entire assessment. The resident's CNA that was present reported she often cried and often without provocation. She told the provider she was depressed because her mother was dead. The resident's CNA reported her mother was not dead and she spoke to her on the phone daily. The most recent behavior notes/assessments on file were from 5/21/22. The resident reportedly refused care from CNAs and locked herself in her bathroom. Patient cursed at staff. She did unlock the door and go back to bed, but she did not allow staff to put a gown on her. Staff verbally reported on this date that the resident had episodes of mood swings/anger at times. This was not documented recently. Staff denied any episodes of physical aggression/refusal of care.			

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	A nursing progress note, dated 8/4/22 at 4:34 p.m., indicated Resident 32 had been sitting by the front door and waited until a visitor came in and attempted to go through the front doors. Staff were able to intervene and stopped her. She was redirected back to the main nurses' station. When asked, Resident 32 indicated she wanted to go outside. Staff indicated she could go to the courtyard if she wanted, but Resident 32 did not want to. She wanted to go outside so she could leave. Staff told her she could not leave by herself, so she wheeled herself toward the nurses' station and called the staff member a "mean bitch." The record lacked documentation of Resident 32's specific choices being offered as interventions on 8/4/22 when she expressed her desire to go outside and leave. Interventions in record included involving family in behavioral care plan, offering elected diversional activities, redirecting to communal activity, and/or offering other options of how to appropriately channel her anger/frustration. The record lacked documentation that an updated elopement risk assessment had been completed on or after 8/4/22 after her attempt to exit the front door. A Social Service Progress note, dated 8/5/22 at 1:18 p.m., indicated SSD was notified by staff that Resident 32 had wandered into the Service hallway off of the 500-hall. She had been easily redirected and returned to her room after she explained she had been trying to go somewhere in the facility but did not know the way. Resident 32 recently had sat by the front entrance to the facility and attempted to exit unassisted when visitors entered but was also redirected at that			

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	time. Resident was agreeable to staff redirection. Resident has dementia and became disoriented of location within the facility at times. Outcome and Prevention included the resident information was placed in the elopement binder. Staff were to monitor resident's behavior. Encourage engagement in activities and socialize with others. Writer to follow up with the family regarding potential move to secure memory care unit. The record lacked documentation of the date/time Resident 32 had wandered onto the staff service-hall on 8/5/22. The record lacked documentation of Resident 32's specific choices being offered as interventions on 8/5/22 when staff had reported it, she wandered onto the Staff Service hallway. The record lacked documentation than an updated elopement risk assessment had been completed on or after 8/5/22 related to the SSD's progress note that Resident 32 had wandered on the service-hall. Nursing progress notes after 8/4/22 until 8/9/22 were reviewed and indicated Resident 32 had remained pleasant, cooperative, and had not developed any signs of aggression, refusal of care, or attempts to elope. A Social Service progress note, dated 8/8/22 at 1:30 p.m., indicated Resident 32's family member was notified of a room move to the secured memory care unit due to Resident 32's recent attempts to go outside, and that the resident and family member were agreeable to her being moved on 8/9/22. A room move notification also dated 8/8/22 was			

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	signed by Resident 32 which waived her rights to a 48-hour notice but did not indicate a reason for the room move. Resident 32 was moved to the secured memory care unit on 8/9/22. A nursing progress note, dated 8/10/22 at 10:59 p.m., indicated it had been reported by the CNA that Resident 32 was trying to get out of the unit and was redirected but she became aggressive. She was "brought to order" by a familiar staff from another unit who helped her, changed her, and put her to bed. She continued throwing everything within her reach even when she was talked to, and staff attempted to make her comfortable. At this time for her safety and that of others, she was asked to be sent out after notifying the on-call practitioner, DON, and family member. She was sent to the emergency department (ED) for further evaluation of behavior. Resident 32 returned later that same evening around 10:55 p.m. A nursing progress note, dated 8/11/22 at 9:38 a.m., indicated on 8/10/22 around 2:30 p.m. Resident 32 was having behaviors during that shift. Staff informed writer that resident had been banging on the doors attempting to get out of the unit. When staff attempted to redirect the resident, she became aggressive. She was attempted to hit staff, yelled, and cursed at staff. She was kicking and attempted to bite staff. Resident 32 removed her foot pedal from her wheelchair and swung it around. Another resident, Resident 321 attempted to get around Resident 32, when she swung the foot pedal and it hit Resident 321. The Medical Doctor (MD) was			

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	notified, and an order was obtained to send Resident 32 to emergency department (ED) for evaluation. Resident was sent to the ED and returned several hours later and rested in bed calmly. Resident 32 was placed on 15-minute checks through the night. In the morning, Resident 32 became aggressive again. She attempted to hit staff with a gait belt and was noted to be wandering. She was placed on one-to-one supervision. Her Psych service provider was in the facility and saw the resident. A referral was sent to for an in-patient psychiatric placement, and they were waiting on acceptance. Resident was to continue on one-on-one (1:1) supervision until sent out or until IDT determined it was no longer needed. An acute psychiatric progress note, dated 8/11/22, indicated, " ...patient is seen on this date. Patient has been having acute, major psychiatric and behavioral concerns in the last 24 hours. Patient had been increasingly psychotic and exit seeking. She was aggressive when redirected. Patient was moved back to the memory care unit for safety. Patient became increasingly psychotic and belligerent with others. She reportedly removed parts of her wheelchair and hit another resident. She reportedly was throwing items from her room and unit at staff. Patient was immediately sent to the ER for an evaluation. She returned to this facility within hours with no changes. Patient continued to be psychotic and explosive towards staff. Patient was swinging her gait belt at staff. Patient continued to be persecutory and paranoid of others. Staff has been monitoring her 1:1 Multiple inpatient psychiatric units were contacted for an admission. It appears [name of in-patient psychiatric facility] may be able to admit the patient today. Patient closed her eyes/refused to speak to this provider today."			

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	On 8/11/22, Resident 32 was discharged to the in-patient psychiatric facility. During an interview on 8/18/22 at 3:12 p.m., Resident 32's family member indicated there had only been one discussion about the possibility of moving Resident 32 to the secured memory care unit, but it had been a couple of weeks prior. Since then, she had not had any issues or behaviors until the day they called and asked if they could move her. At that time, he was told about Resident 32's attempt to go onto the staff service-hall. He was told they were moving Resident 32 to the secured memory care unit to monitor recent medication changes to determine if the medications were causing the behaviors. He had spoken to Resident 32 the week before and she seemed like her normal self. During an interview on 8/18/22 at 3:19 p.m., with the DON present CNA 18 indicated she had been working in the memory care unit when Resident 32 began to act out. By the time she got to Resident 32, the resident was being very aggressive, and she was yelling, "No! No! Get away from me!" She was sitting in her wheelchair at the memory care entrance and tried to open the door. When the aids attempted to move her wheelchair away from the door, she continued to pivot her wheelchair to the door and tried to get out. She grabbed the foot petal of her wheelchair and began to swing at us with it. "I don't know what came over her, ever since she moved to memory care even when we took her to her room, she was aggressive. She started calling us names, and cussing at us, I was so scared." The DON indicated that night when her behaviors got bad, staff went to get another CNA from the 500-hall where she had been prior to her move. CNA 20 was able to come over and			

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	get her to stop swinging the pedal and help her calm down a little until they could get her sent to the ER. In the ER they gave her Haldol (an antipsychotic medication) and Benadryl (an antihistamine medication that can cause drowsiness). So, by the time she returned she slept through the night, but by 6:00 a.m., the next morning, she was back up at it again and swinging the gait belt around so that was when the facility put a referral out to a psychiatric hospital. The DON indicated the move to the locked dementia unit had been conducted after the resident attempted to get out the front door and was trying to go on the staff service-hall. In order for a resident to meet the requirement to be admitted to the memory care unit they needed to be comprehensively assessed to determine if the unit would meet their needs. They did not necessarily have to have a diagnosis of dementia, even though Resident 32 did have dementia. Typically, it would not be appropriate to ask the resident being moved to memory care to sign her own transfer notice, especially without an indication as to why. During an interview on 8/18/22 at 4:12 p.m., Registered Nurse (RN) 23 indicated it had been reported to her that Resident 32 was having behaviors. She was called to complete an assessment on Resident 321 after being hit by the wheelchair pedal. RN 23 indicated the CNA on the unit could not redirect Resident 32. She continued to be aggressive, and they eventually had to get a CNA from her previous hall to come help calm her down. By the time EMS (emergency medical technicians) got there, she was sitting calmly in her room, but kept her eyes closed and would not speak.			

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	During an interview on 8/19/22 at 10:19 a.m., CNAs 17 and 24 indicated they both knew Resident 32 well. She had been on their hall prior to her move to memory care. Both CNAs agreed they were shocked to learn that Resident 32 had been moved because she had not seemed all that confused or exit seeking. Resident 32 liked to go through the building and followed staff around to visit with them, but "she was more with it than some for the other residents on this hall." Resident 32's worst days were when she seemed upset for no reason and just cried, but even then, it was easy to redirect her with conversation, activities, T.V., or a hug. Maybe she could have been moved to another hall where she would not have been able to see the service-hall, or she could have been moved closer to the nurses' station. CNA 17 indicated she was not surprised Resident 32, "lost it" back there, because no one back there could really converse with her on her cognitive level. During an interview on 8/19/22 at 10:23 a.m., the Maintenance Director indicated he knew Resident 32 in passing. She was always in the hallways visiting with someone and when he walked by, she would call out to him and made jokes with him about his name. She seemed quite pleasant. During an interview on 8/19/22 at 10:25 a.m., the Activity Director (AD) indicated Resident 32 loved activities. She participated in almost all of them on a regular basis. If she was having one of her bad days, we made sure to go encourage her to come down, and usually by the end of the activity she was back to her happy self. She did wander through the building but more or so to visit with people, and the AD never witnessed any exit seeking behaviors.			

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	During an interview on 8/19/22 at 10:28 a.m., the Business Office Manager (BOM) indicated she knew Resident 32 only from the couple of times she would come up to the front offices looking for candy. She would sit by the fireplace and visit with people as they passed by. During an interview on 8/22/22 at 11:02 a.m., the Social Service Director (SSD) indicated Resident 32 had been a resident of the facility since October of 2020. She initially came for rehabilitation, then moved to long term care. Overall, she was pleasant, and cooperative. Her moods would fluctuate, for example one minute she may have been crying over nothing, then turn around and start laughing. Candy was a big motivator for her, she also liked to talk with her family on the phone, group activities, and she enjoyed individual activities like puzzles or word finds. For the most part she was easily redirectable with those interventions, depending on the day, sometimes it might take more time to get her attention turned away. Her behaviors seemed to increase in the last month, when she tried to get out the front door, and then attempted to go on the staff service-hall. The last time she went through the service-hall was when they decided she might need some more interventions like the memory care unit. They gave her the 48-hour notice, and she signed it. During an interview on 8/22/22 at 11:17 a.m., with the SSD present, the Memory Care Director (MCD) indicated Resident 32 moved to the unit on 8/9/22. From what she remembered, the first day everything seemed "ok." The MCD was not there the evening of the 10th, but it appeared she tried to go out the front doors of the unit, and when she was redirected and told she could not leave the unit was when she "lost it" and became			

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	aggressive. She was not able to be redirected. The MCD indicated she did not know what specific interventions had been offered, but nothing seemed to work. The SSD indicated her displayed behaviors those couple of days on the memory care unit were a significant change from her baseline. It appeared, "she just shut down." On 8/18/22 at 3:30 p.m., the DON indicated there was no specific policy for Memory Care unit but provided a brochure/pamphlet titled, "Memory Care at Avon," which included the following information: Familiar, Home-Like Environment...every inch of our community supports resident centered care and is designed to help residents function at their optimal level. Activity-Based Care...we promote physical, emotional, social, and spiritual well-being by creating daily programs of fun group activities deigned to appear to personal interest. Resident centered care is the heart of our memory care program ...." On 8/22/22 at 11:30 a.m., the Administrator (ADM) provided a copy of the facility's Alzheimer's/Dementia Special Care Unit State Form 48896, dated 12/14/21. The Disclosure form indicated, the memory care unit did have a mission statement as follows: "Autumn Woods is designed to affirm and preserve the dignity of the individual, recognizing that each person has unique physical, mental, social and spiritual needs that must be understood, met and respected. The process begins with the comprehensive assessment of the individual's needs and abilities ...." On 8/19/22 at 1:50 p.m., the DON provided a copy of current, but undated facility policy titled, "Resident Rights." The policy indicated, " ...The			

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	Resident has the right to a dignified existence ... (a) Transfer and Discharge, (2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical records must be documented. (4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (ii) record the reason in the resident's clinical record, (iii) Include in the notice the items described in paragraph (a)(6) of this section ... A facility musts care for its residents in a manner an in an environment that promotes maintenance or enhancement of each resident's' quality of life ... the resident has the right to (1) choose activities, schedules and health care consistent with his or her interests, assessments, and plans of care; (2) Interact with members of the community both inside and outside the facility ...." 3.1-37			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Recertification and State Licensure Survey. This visit included the Investigation of Nursing Home Complaints IN00381444, IN00384815, and IN00386296. Complaint IN00381444 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00384815- Unsubstantiated due to lack of evidence. Complaint IN00386296 - Substantiated. No deficiencies related to the allegations are cited.	R 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	

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	Survey dates: August 19 and 22, 2022. Facility number: 000141 Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 1, 2022.			
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to maintain an updated fire and disaster	R 0092	The facility will ensure this requirement is met through the	09/16/2022

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	preparedness plan and binder, failed to ensure all staff had annual fire and disaster education, and failed to complete 12 fire drills annually covering each shift. These deficiencies had the potential to effect 26 of 26 residents who resided in the Assisted Living (AL) facility. Findings include: 1. On 8/18/22 at 2:35 p.m., the Emergency Disaster binder was reviewed. The last facility update of the Emergency Action Plan was completed on 1/21/21. The last facility update of the Disaster Manual was completed on 5/2/2019. The Incident Command Team Chart indicated Admin 1 would have been the Incident Commander. No current staff member was listed as the Incident Commander. On 8/18/22 at 3:19 p.m., after a review of the Emergency Disaster binder with the Assisted Living Director (ALD), she indicated the person listed as the Administrator was not the current administrator. The Emergency Preparedness binder should have been kept updated with all the correct information. The maintenance supervisor (MS 2) was responsible for keeping the Emergency Disaster binder updated. On 8/18/22 at 3:26 p.m., the ALD indicated the Emergency binder should have been updated. The staff who were listed as current staff in the Emergency binder who were no longer at the facility were the former Administrator 1 (Admin 1), the former Administrator 2 (Admin 2), the former Maintenance Supervisor 1 (MS 1), the former Dietary Supervisor (RDS), the former Social Services Director (SSD), former Human Relations staff (HR), and the former Director of Property Maintenance (DPM).		following corrective measures: 1. No residents were harmed. The Emergency Binder had been updated. 2. All residents have the potential to be affected. See below for corrective measures. 3. The policies on Disaster Plan and Fire Emergency Preparedness were reviewed and no changes were indicated. AL staff, along with maintenance staff will be educated on fire and disaster preparedness. The HFA will audit the Emergency Binder weekly for 6 weeks to ensure it is up to date and until 100% compliance is achieved, then monthly for 6 months and until 100% compliance is maintained. The HFA will audit fire drills to ensure they are conducted according to policy weekly for 3 months and until 100% compliance is achieved, then monthly for 6 months and until 100% compliance is maintained. The HR Director will audit AL training weekly for 6 weeks and until 100% compliance is achieved, then monthly for 6 months and until 100% compliance is maintained to ensure training is completed timely. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plans of action adjusted accordingly.	

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	155236	A. BUILDING 00 B. WING	08/22/2022

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	2. On 8/19/22 at 9:30 a.m., AL (Assisted Living) staff education was reviewed for Fire Safety and Workplace Emergencies and Natural Disasters. Two current staff members were not up to date. a. CNA 16's education was reviewed. It showed the last time she completed Fire Safety was 3/27/21 and Workplace Emergencies and Natural Disasters: An Overview was last completed on 7/3/21. b. Qualified Medication Aide (QMA) 17's education was reviewed. It showed the last time she completed Fire Safety was 5/26/21. On 8/18/22 at 2:23 p.m., the ALD indicated the day shift staff was one QMA and one CNA, with one CNA who floated between shifts. The night shift only had one QMA. The nursing schedule was reviewed from 8/15/22 to 8/22/22. a. QMA 17 was the only staff member in the AL. She worked the night shift for 7 shifts: 8/15/22 through 8/19/22, and 8/21/22 and 8/22/22. b. Certified Nursing Aide (CNA) 16 worked 2 day shifts and 2 evening shifts all on 8/20/22 and 8/21/22. 3. On 8/18/22 at 2:25 p.m., the Assisted Living Director (ALD) indicated fire drills should have been completed on all shifts. On 8/23/22 at 10:45 a.m., the current Maintenance Supervisor (MS 2) indicated he was promoted to maintenance supervisor at the end of October 2021. He was not aware of AL having their own specific fire drills. On Long Term Care (LTC), the fire drills were completed once a month on different shifts. The			

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	only AL fire drills completed in the last 12 months were both on day shift on 10/30/21 and 1/4/22. On 8/19/22 at 2:21 p.m., the current Administrator indicated the disaster plan should have been updated annually. On 8/19/22 at 2:25 p.m., the Regional Clinical Support indicated the disaster plans should have been updated at least annually and with any changes. On 8/22/22 at 12:06 p.m., DON indicated the AL Emergency Preparedness binder and the Disaster Manual should have been updated annually according to policy. On 8/22/22 at 11:00 a.m., the Director of Nursing (DON) indicated for Fire Safety, the fire drills were done facility wide. A current policy, titled, "Disaster Plan," dated 11/21, was provided by the DON on 8/22/22 at 11:15 a.m. A review of the policy, indicated, " ...It is the policy of this facility to continue quality care during time of major disasters and/or emergencies ...The facility will complete an annual Risk Assessment. The will be completed by the maintenance staff/designee ...." A current policy, titled, "Facility Fire Plan and Procedure," dated 2017, was provided by the DON on 8/22/22 at 11:15 a.m. A review of the policy, indicated, " ...All personnel are responsible for the knowledge and compliance with the Faciliity Fire Plan...This FFP shall be provided during each staff orientation and during the annual in-service ...."			
R 0217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency			

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Bldg. 00	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on interview and record review, the facility failed to ensure resident's service plans included information for the care of diagnosed mental illnesses for 2 of 7 residents reviewed for mental illness care (Resident 26 and 11). Findings include: After entrance conference, the facility provided a list of assisted living residents with mental	R 0217	The facility will ensure this requirement is met through the following corrective measures: 1.Residents 26 and 11 were not harmed and their service plans were revised to include mental health needs. 2. All residents with mental health needs have the potential to be affected. Residents were reviewed	09/16/2022

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	illnesses. Residents 26 and 11 were on the list with a diagnosis of major depressive disorder. 1. On 8/18/22 at 2:10 p.m., Resident 26's record was reviewed. He was admitted on 4/11/2018. His diagnoses included, but were not limited to major depressive disorder (mental health disorder with a persistently depressed mood or loss of interest in activities causing significant impairment in daily life), anxiety (state of excessive uneasiness and apprehension), and hypertension (high blood pressure). His service plan was reviewed, he did not have a plan of care for major depressive disorder. His Minimum Data Set (MDS) assessment, dated 9/7/21, indicated Resident 26 had a history of feeling down, depressed, or hopeless, had felt tired or having little energy, and had felt bad about himself or that he was a failure or had let himself or his family down. 2. On 8/18/22 at 2:30 p.m., Resident 11's record was reviewed. His diagnosis included, but was not limited to, major depressive disorder. His service plan was reviewed, he did not have a plan of care for major depressive disorder. On 8/22/22 at 11:02 a.m., the Director of Nursing (DON) indicated Residents' 26 and 11 service plans did not indicate care for their major depressive disorder diagnosis but they should have had a plan of care of these diagnoses. A current policy titled, "Resident Evaluation," dated 6/19, was provided by the DON on 8/22/22 at 11:15 a.m. A review of the policy indicated, "		to ensure service plans include mental health when indicated. 3. The Resident Evaluation policy was reviewed and no changes indicated at this time. The AL Director will be re-educated on this policy. The DON or her designee will review 3 resident service plans weekly X 6 weeks and until 100% compliance is achieved, then 5 per month for 6 months and until 100% compliance is maintained to ensure mental health needs are addressed. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	...It is the policy of this facility to evaluated the needs of the resident upon admission, biannually and with significant change ...to ensure care and services needed are received and within the scope of the assisted living's ability to provide the care and services ...The facility will determine the content of the evaluation, but must contain at a minimum the following: The resident's physical, cognitive, and mental status ...The evaluation will be documented electronically and maintained in the medical record ...."			