| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155793 | A. BUILDING 00<br>B. WING | 11/22/2022 |

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| HAMILTON TRACE OF FISHERS | 11851 CUMBERLAND RD<br>FISHERS, IN 46037 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00391026. This visit included a State Residential Licensure Survey.<br><br>Complaint IN00391026 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F684.<br><br>Survey dates: November 15, 16, 17, 18, 21 and 22, 2022<br><br>Facility number: 012644<br>Provider number: 155793<br>AIM number: 201046710<br><br>Census Bed Type:<br>SNF/NF: 56<br>SNF: 46<br>Residential: 70<br>Total: 172<br><br>Census Payor Type:<br>Medicare: 16<br>Medicaid: 41<br>Other: 45<br>Total: 102<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on December 5, 2022 | F 0000 | The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this SOD Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review. | |
| F 0585<br>SS=D<br>Bldg. 00 | 483.10(j)(1)-(4)<br>Grievances<br>§483.10(j) Grievances.<br>§483.10(j)(1) The resident has the right to | | | |

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

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| | voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.<br><br>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.<br><br>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:<br>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of | | | |

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| | independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;<br>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;<br>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;<br>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;<br>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to | | | |

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| | be taken by the facility as a result of the grievance, and the date the written decision was issued;<br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. | | | |
| | Based on interview and record review, the facility failed to ensure prompt attention was provided to a resident with concerns regarding missing clothing items and failed to ensure a grievance policy was developed for use with any resident concerns. This deficient practice has the potential to affect all 102 of 102 residents of the health care portion of the facility. (Resident 54)<br><br>Findings include:<br><br>In an interview with Resident 54 on 11-21-22 at 10:40 a.m., she indicated she was missing a pair of gray slacks and a pair of lavender Capri pants. She estimated the slacks had been missing for 2 to 4 weeks and the Capri pants had been missing for 2-4 months. She indicated the laundry staff and a nurse were aware of the missing items and had checked the laundry and lost and found items without success.<br><br>In an interview on 11-21-22 at 11:00 a.m., with the Environmental Service Director, she indicated she was familiar with the 2 missing items belonging to | F 0585 | 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>Resident 54's missing items have been replaced and labelled. The facility has a policy for grievances.<br><br>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken<br>Residents residing in the facility have the potential to be affected by the alleged deficient practice. An audit was completed to determine if residents were missing any clothing items. Any reports of missing clothing will be placed on a grievance form per the facility grievance policy.<br><br>3) What measures will be put | 11/22/2022 |

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| | Resident 54. She indicated she had spoken to Resident 54 "numerous times" and indicated this had been going on for at least four to five months. She indicated she had not filed a grievance form for the resident's missing items. She indicated she had taken the lost and found items to Resident 54 personally to see if any of the items were hers and the resident indicated they were not.<br><br>In an interview on 11-21-22 at 11:15 a.m., with the Executive Director (ED), he indicated he would check to verify if any grievances had been filed for Resident 54's missing items. He indicated it is normal practice for a grievance to be filed for any missing items. He indicated if a resident or family member reports a missing item, if the item cannot be located, the person is reimbursed for the item. A copy of the facility's grievance policy was requested at this time.<br><br>In an interview on 11-21-22 at 3:30 p.m., The ED indicated he had been unable to locate a grievance form for Resident 54's missing items and had completed one for her earlier in the afternoon. He indicated he had been unable to locate a copy of a grievance policy thus far. A copy of the facility's grievance policy was again requested at this time.<br><br>On 11-22-22 at 9:40 a.m., the Corporate Nurse (CN) provided copy of policy on Resident Rights. She clarified she had checked with her corporate advisor who shared with her there is no specific policy grievance policy, only a Resident Rights policy.<br><br>On 11-22-22 at 9:40 a.m., the CN provided a copy of the facility's "Resident Rights" policy. This policy was indicated to be the current policy utilized by the facility and has a original policy | | into place and what systemic changes will be made to ensure that the deficient practice does not recur<br>Management associates educated on the grievance policy. Will be educated upon hire and annually.<br><br>4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place<br>Administrator or designee will interview 5 residents to ensure there are no concerns for missing clothing. Audits will occur weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee. | |

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| | date of 6-6-19 and without any indicated revision date. This policy indicated, "It is our policy that residents shall be treated with kindness, respect and dignity by associates, volunteers, contractors and visitors...21. Voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal; 22. Have the facility respond to his or her grievances..."<br><br>3.1-7(a)(1)<br>3.1-7(a)(2)<br>3.1-7(b) | | | |
| F 0607 SS=D Bldg. 00 | 483.12(b)(1)-(5)(ii)(iii)<br>Develop/Implement Abuse/Neglect Policies<br>§483.12(b) The facility must develop and implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br><br>§483.12(b)(4) Establish coordination with the QAPI program required under §483.75.<br><br>§483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. | | | |

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| | §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.<br><br>§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.<br>Based on interview and record review, the facility failed to ensure a criminal background check was obtained for a new hire per facility policy for 1 of 10 personnel files reviewed. (Certified Nursing Assistant (CNA) 15)<br><br>Findings include:<br><br>The personnel files of 10 staff members were provided by the Nurse Consultant on 11/21/22 at 8:58 a.m. CNA 15's personnel file was reviewed. It indicated CNA 15's employment start date was 1/26/22. The file included a criminal background check for CNA 15 that had been obtained on 8/25/21.<br><br>An interview was conducted with the Human Resource Director (HRD) on 11/22/22 at 10:14 a.m. HRD indicated CNA 15 was a new CNA and had completed her clinicals at the facility. The facility had decided to hire her after she had completed her clinical's as a facility employee. HRD had not obtained a criminal background check on CNA 15 prior or at that time of hire. She had used the criminal background check that had been obtained by the school entity for CNA 15.<br><br>An interview was conducted with the Executive Director on 11/22/22 at 10:57 a.m. He indicated CNA 15 was a part-time staff person.<br><br>An Associate Background Screening policy was | F 0607 | 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>New background check for CNA 15 completed.<br><br>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken<br>Residents residing in the facility have the potential to be affected by the alleged deficient practice. An audit was completed for associates hired in the last 60 days to ensure background checks have been completed.<br><br>3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur<br>Human Resources will be educated on the associate screening policy. Associates will not be allowed to work without a criminal background check.<br><br>4) How the corrective action(s) | 01/06/2023 |

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| | provided by the Executive Director on 11/22/22 at 10:37 a.m. It indicated "Policy. Pursuant to Indiana Code (IC) 16-28-13-4, heart of CarDon, LLC (the Company) does not knowingly hire anyone who has a conviction for any of the criminal offenses listed in the Excludable Convictions List. Anyone accepting employment (both licensed and unlicensed staff) will be subject to a limited criminal history check as a condition of employment. This inquiry will be made to the Indiana State Police Central Repository, by use of a designated third-party vendor, within 3 days of hire for all unlicensed and licensed staff. All new hire searches will also be subject to a criminal history search using a social security trace and criminal court record, in addition to the Indiana State Central Repository check, a check of the Sex Offender Registry, and a GSA [General Services Administration], and OIG [Office of Inspector General] search..."<br><br>An abuse policy was provided by the Executive Director on 11/15/22 at 3:53 p.m. It indicated "...I. Background Screening Investigations. Our Community will not knowingly hire any individual who has a history of abusing other persons. The Community will conduct employment background screening checks, references and criminal conviction investigation checks on individuals making application for employment with this facility. 1. The Human Resource Consultant, or other person designated by the administrator, will conduct employment background checks, reference checks and criminal conviction checks on persons making application for employment with this Community. Such screening will be initiated prior to employment or offer of employment..."<br><br>3.1-28(a) | | will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place<br><br>HR or designee will audit 5 associate files to make sure background checks have been completed. Audits will occur weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee. | |

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| F 0641 SS=A Bldg. 00 | 483.20(g)<br>Accuracy of Assessments<br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>Based on interview and record review, the facility failed to ensure accuracy of a Minimum Data Set (MDS) assessment for Preadmission Screening and Resident Review (PASRR) for 1 of 2 residents reviewed for PASRR. (Resident 78)<br><br>Findings include:<br><br>The clinical record for Resident 78 was reviewed on 11/16/22 at 2:00 p.m. The diagnosis for Resident 78 included, but was not limited to, schizoaffective disorder, bipolar type.<br><br>Resident 78 had received a PASRR Level II on 10/25/21.<br><br>The annual MDS assessment completed on 10/14/22 indicated the resident had not been evaluated for a PASRR level II.<br><br>An interview was conducted with the MDS Coordinator on 11/17/22 at 11:23 a.m. She indicated the annual MDS assessment completed on 10/14/22 for Resident 78 was coded in error. It should have been marked yes instead of no.<br><br>An interview was conducted with the Director of Nursing on 11/18/22 at 9:14 a.m. He indicated the facility did not have a policy regarding MDS accuracy. The facility follows the RAI (Resident Assessment Instrument) manual.<br><br>3.1-31(d) | F 0641 | 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>MDS assessment for resident 78 was corrected during the survey.<br><br>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken<br>Residents who require a Level II have the potential to be affected by the alleged deficiency. An audit was completed to ensure MDS accuracy.<br><br>3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur<br>MDS associates were educated regarding MDS accuracy. Education will occur upon hire and annually.<br><br>4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place<br><br>DON or designee will audit MDS | 11/22/2022 |

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| | | | assessments for residents who require Level II for accuracy. Audits will occur weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee | |
| F 0677<br>SS=D<br>Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>Based on interview, observation, and record review, the facility failed to provide the necessary services to maintain good grooming and personal hygiene for a resident who was unable to carry out activities of daily living by not ensuring twice weekly showers/complete bed baths and providing incontinent care timely for 1 of 4 residents reviewed for activities of daily living (ADLs). Resident 92<br><br>Findings include:<br><br>The clinical record for Resident 92 was reviewed on 11/17/22 at 1:30 p.m. Resident 92's diagnoses included, but not limited to, systemic Lupus, abnormal posture, difficulty in walking, pressure ulcers to bilateral heels (unstageable) and congestive heart failure. | F 0677 | 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>Resident 92 no longer resides in the facility.<br><br>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken<br>Residents residing in the facility have the potential to be affected by the alleged deficient practice and have been audited to ensure showers are offered at least twice weekly and pericare is being | 01/06/2023 |

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| | Resident 92's admission MDS (minimum data set) dated 11/4/22 indicated, Resident 92 was cognitively intact; required extensive assistance of one person for bed mobility, toileting, and personal hygiene; extensive assistance of two persons for transfers; was frequently incontinent of urine; and indicated it was very important for them to choose between a tub bath, shower, bed bath or sponge bath.<br><br>An interview with Resident 92 was conducted on 11/15/22 at 12:15 p.m. During the time of the interview, Resident 92 was observed to have gray whiskers on her chin. Resident 92 indicated, she preferred not to have the whiskers on her chin, but the staff had not offered to shave them for her on her shower days. She further indicated, she had not received showers/complete bed baths twice weekly, nor had it been offered to wash her hair. When questioned about incontinent care, Resident 92 indicated, some of the staff did not perform peri-care when changing her incontinent brief, but rather just changed the brief nor had they changed it as frequently as needed.<br><br>An observation was made on 11/17/22 at 11:30 a.m. of the unit's shower book. The shower book indicated, Resident 92's shower days were Tuesdays and Fridays on day shift. A review of the shower book indicated, Resident 92 only had two completed shower sheets for November 2022. The shower sheets were dated 11/1/22 and 11/11/22 and both indicated, Resident 92 had refused her shower/complete bed bath for those two instances. Resident 92 had not been offered a shower/complete bed bath, shaving, and/or hair washing at least twice weekly.<br><br>An interview with UM (unit manager) 6 was | | provided timely.<br><br>3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur<br>Nursing associates educated on the ADL policy including offering showers at least twice weekly and providing pericare timely.<br>Education will occur upon hire and annually.<br><br>4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place<br><br>DON or designee will interview 5 residents to ensure showers are offered at least twice weekly and pericare is being provided timely.<br>Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155793 | A. BUILDING 00<br>B. WING | 11/22/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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|---|---|---|---|---|
| | conducted on 11/17/22 at 11:46 a.m. UM 6 indicated, she was unable to locate any additional shower sheets for Resident 92 at the time.<br><br>In Resident 92's electronic health record (EHR) under the Tasks point of care for bathing, it indicated the following:<br>- On 11/11/2022 at 2:31 p.m., Resident 92 received a partial bed bath.<br>- On 11/14/2022 at 1:13 p.m., Resident 92 received a partial bed bath.<br>- On 11/15/2022 at 8:05 p.m., Resident 92 received an "other" bath.<br>- On 11/17/2022 at 1:39 p.m., Resident 92 received a partial bed bath.<br>No further baths had been recorded for Resident 92.<br><br>An interview with Resident 92 was conducted on 11/17/22 at 2:12 p.m. During the interview, it was observed that Resident 92 still had gray whiskers on her chin. Resident 92 indicated, her incontinent brief had been changed that morning when they got her up for the day, but had not been checked or changed since then.<br><br>An interview with UM 6 was conducted on 11/17/22 at 3:01 p.m. UM 6 indicated, residents who are incontinent of urine or bowel should be checked and changed every two hours or if the resident knew they have been incontinent the expectation would be that they put the call light on, but she could not provide an explanation as to why a resident who had a care plan which indicated, that they were at times unaware of their own incontinence would not have checked and/or changed every two hours.<br><br>Resident 92's care plan dated 11/1/22 indicated, she was incontinent of urine and was not always | | | |

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|---|---|---|---|---|
| | aware of the need to toilet or that incontinence had occurred. The interventions included, but not limited to, assist to toilet as needed due to mobility and mental status limitation(s), provide education and use of absorbent incontinent products, to place a pad on bed, and provide incontinence care after toileting as needed.<br><br>The facility was unable to provide an ADL policy.<br><br>This Federal tag relates to complaint IN00391026.<br><br>3.1-38(a)(3)<br>3.1-38(b)(2)<br>3.1- 38(b)(4) | | | |
| F 0679<br>SS=E<br>Bldg. 00 | 483.24(c)(1)<br>Activities Meet Interest/Needs Each Resident<br>§483.24(c) Activities.<br>§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.<br>Based on observation, interview and record review, the facility failed to provided an ongoing activity program on the memory care unit of the facility and assist a resident to the activity of her choice in a timely manner for 5 of 6 residents reviewed for activities. (Residents' 28, 61, 77, and 80, 318)<br><br>Findings include: | F 0679 | 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>Residents 28, 61, 77 and 80 reside on the memory care unit. The Memory Care Facilitator has developed an activities calendar and activities are occurring on the memory care unit. | 01/06/2023 |

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|---|---|---|---|---|
| | 1. The clinical record for Resident 80 was reviewed on 11/16/22 at 10:25 a.m. Her diagnoses included, but were not limited to, Alzheimer's disease.<br><br>Resident 80's 8/22/22 activities care plan, last reviewed/revised on 9/2/22, indicated she would engage in the Cherished Memories model of activities including activities from prior lifestyle, physical, sensory, spiritual, social, and cognitive activities. She enjoyed group games and socials. Interventions were to provide her with an activity calendar to identify activities of interest and for staff to encourage her to engage in preferred group activities like games and socials.<br><br>The 11/2/22 physician note read, "<br>...2. Alzheimer's dementia without behavioral disturbance, unspecified timing of dementia onset...Encourage Brain stimulation activities daily. Continue to encourage participation in activities at the unit."<br><br>2. The clinical record for Resident 28 was reviewed on 11/16/22 at 10:50 a.m. Her diagnoses included, but were not limited to, Alzheimer's disease.<br><br>Resident 28's 2/7/21 activities care plan, last reviewed/revised on 10/28/22, indicated she enjoyed independent and group activities and would benefit from the Cherished Memories programming. She enjoyed reading, doing word find puzzles, listening to music, socializing with her peers, church, visiting with family and resting in her room. Interventions were to invite/encourage her to join preferred activities such as church service, social events, and small group activities.<br><br>An interview was conducted with Family Member | | Resident 318 no longer resides in the facility.<br><br>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken<br>Residents residing in the facility have the potential to be affected by the alleged deficient practice and have been audited to ensure residents on the memory care unit have ongoing activities and residents are assisted to activities timely.<br><br>3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur<br>Nursing associates educated to provide ongoing activities on the memory care unit. Associates also educated to assist residents to activities timely. Education will occur upon hire and annually.<br><br>4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place<br><br>DON or designee will complete random audits at various times on the memory care unit to ensure activities are occurring and will interview 5 residents to ensure | |

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|---|---|---|---|---|
| | 28 on 11/16/22 at 11:20 a.m. She indicated Resident 28 complained to her about not having anything to do on the unit. When she visited in the evenings, she did not see any activities occurring, but didn't really know what went on in the middle of the day.<br><br>3. The clinical record for Resident 77 was reviewed on 11/17/22 at 10:00 a.m. His diagnoses included, but were not limited to, dementia.<br><br>Resident 77's 1/4/21 activities care plan, last reviewed/revised on 10/7/22, indicated he would benefit from the Cherished Memories model of group activities and enjoyed church. Interventions were to give reminders and transport him to activities of choice such as music, church, and socials.<br><br>4. The clinical record for Resident 61 was reviewed on 11/17/22 at 10:05 a.m. Her diagnoses included, but were not limited to, dementia.<br><br>Resident 80's 4/21/22 activities care plan, last reviewed/revised on 10/25/22, indicated she would engage in the Cherished Memories model of activities including activities from prior lifestyle, physical, sensory, spiritual and cognitive activities. Interventions were to provide her with an activity calendar to identify activities of interest and for staff to encourage her to engage in preferred group activities.<br><br>The Cherished Memories Activities Calendar from October, 2022 was posted in the activities room of the unit. It included activities like daily chronicle, stretch and exercise, game time, snacks and beverage, devotional and prayer, and crafts. There was no November, 2022 calendar posted. | | assistance to activities is being provided timely. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee. | |

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|---|---|---|---|---|
| | On 11/17/22 at 9:40 a.m. the white board in the activities room read, "snack time, no money, please leave her alone, popcorn, outside later when it is warmer."<br><br>An observation was made on 11/16/22 from 10:30 a.m. to 10:50 a.m. Resident 28 and Resident 80 were sitting in their wheel chairs in the hallway between the dining room and nurse's desk. Both residents were looking around the unit and not engaging in any activities. There were no group activities occurring on the unit at this time.<br><br>An observation was made on 11/17/22 at 9:32 a.m. Resident 80 was sitting in the television room with her head down and eyes closed. She would lift her head periodically, then put it back down again. The television was on a popular television network that plays seasonal movies during the holidays. There were 5 other residents in the room with her and none of them were watching the television. There were no group activities occurring on the unit at this time.<br><br>An observation was made on 11/17/22 at 9:39 a.m. Resident 28 was sitting in her wheel chair in front of the nurse's station with her head down and eyes closed. Resident 77 and Resident 61 were also sitting in their wheel chairs in front of the nurse's station. Resident 77 had his head down and eyes closed. Resident 61 was looking straight ahead.<br><br>On 11/17/22 at 10:03 a.m. Resident 80 independently ambulated in her wheel chair into the activity room towards the exit door. She looked out the window of the door for a few moments, then ambulated back into the television room and sat in front of the television. She began fiddling with a bag in her lap, and did not watch | | | |

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|---|---|---|---|---|
| | television. There were no group activities occurring on the unit at this time.<br><br>On 11/17/22 at 10:20 a.m., Resident 80 ambulated into the hallway restroom by the nurse's station. Resident 28 was still sitting in the hallway in front of the nurse's station, just looking around. Resident 61 was also still in front of the nurse's station just staring straight ahead. Resident 77 was in his room in his wheel chair with his head down and eyes closed. There were no group activities occurring on the unit at this time.<br><br>On 11/17/22 at 11:10 a.m., an observation was made. Resident 80 was sitting in her wheel chair in front of the nurse's station. Resident 61 was now in the dining room sitting at a table. She did not have any food or drink in front of her. There were 6 other residents, including Resident 77, in the dining room at this time, none with food or drink. There were no group activities occurring on the unit at this time.<br><br>An observation was made on 11/17/22 at 11:34 a.m. Resident 80 was in the dining room at a table with 3 other residents. There were a total of 11 residents, including Resident 77, sitting at tables in the dining room, waiting for lunch. There were no group activities occurring on the unit at this time. Resident 28 was still sitting in her wheel chair in front of the nurse's station with her head down and eyes closed.<br><br>An observation was made on 11/17/22 at 1:16 p.m. Resident 80 was sitting in her wheel chair in the hallway in front of the nurses station, just looking straight ahead. Resident 61 was was sitting nearby in the hallway, looking down, with her eyes closed. Resident 228 was also nearby with her head down most of the time, but looking | | | |

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| | around periodically. There were no group activities occurring on the unit at this time..<br><br>On 11/17/22 at 1:21 p.m., an observation was made. Resident 80 followed another resident into the television room. Resident 61 was snow sitting in front of the nurse's station at a different location with her head still down, looking around periodically.<br><br>On 11/17/22 at 2:09 p.m., an observation was made. Resident 80 was sitting in her wheel chair in front of the nurse's station, looking around. Resident 61 was sitting in her wheel chair in front of the nurse's station, looking straight ahead. Resident 61 was still sitting in front of the nurse's desk, as she tried to get up from her wheel chair moments earlier, but was told to sit back down. Resident 77 was in his bed.<br><br>An interview was conducted with LPN (Licensed Practical Nurse) 32 on 11/17/22 at 2:11 p.m. She indicated she worked on the unit 2 to 3 days a week for the last couple of weeks. She indicated the unit did not currently have an activity staffperson for the unit, as they previously did. It had been "about 6 weeks." The last activities staffperson, the MCF (memory care facilitator,) provided activities on an ongoing basis, "all day long until dinner time." Resident 80 liked to do arts and crafts. She pointed to some pumpkins and cats hanging on the wall of the activity room and indicated those were the types of crafts provided for the residents. The previous MCF would ask residents questions and read the daily chronicle to stimulate them. She would put a letter on the white board in the activity room and ask for a fruit that started with that letter, things like that. She'd do a snack and crafts in the afternoon. "They may be more bored now." The previous | | | |

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| | MCF would bring many of the residents into the activity room, including Resident 61. Resident 80 would do crafts. Resident 28 would be passively present for activities, but participate in crafts. The October, 2022 calendar was probably still posted, because that was the last time they had an activity person for the unit. LPN 32 pointed to a large wall next to the nurses station entitled Life Enrichment and indicated all the daily activities used to be posted there in large print. At this time, the wall was completely blank. Resident 77 would also go to activities when they had them, but was more passively participating.<br><br>An interview was conducted with the AD (Activity Director) on 11/17/22 at 2:25 p.m. She indicated she'd worked at the facility since August, 2021. She took down the activities posted on the wall on the memory care unit, because it was from October, 2022. She did not have anything with which to replace it. Usually the MCF took care of that.<br><br>An interview was conducted with the ED (Executive Director) in the presence of the AD on 11/17/22 at 2:29 p.m. The ED indicated there was typically an ongoing activity program, but they had turnover in the MCF position.<br><br>On 11/21/22 at 11:49 a.m., the ED indicated they did not have an activity policy and stated, "We just follow the regs [regulations.]"5. The clinical record for Resident 318 was reviewed on 11/18/22 at 10:04 a.m. Resident 318's diagnoses included, but not limited to, muscle spasms, obstructive uropathy, mood disorder, anxiety disorder, major depressive disorder, and lack of coordination.<br><br>Resident 318's admission MDS (minimum data set) dated 11/3/22 indicated, Resident 318 was | | | |

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| | cognitively intact, and required extensive assistance of one person for bed mobility and transfers. It further indicated, locomotion off the unit had occurred only once or twice during assessment period.<br><br>An interview with Resident 318 was conducted on 11/15/22 at 2:36 p.m. Resident 318 was sitting in her room in her wheelchair. She indicated, she was waiting for a nurse to take her to the activity room because she wanted to play the card game that was scheduled for that day at 2 p.m. The interview was immediately stopped and facility staff was informed of Resident 318's request.<br><br>RN (Registered Nurse) 8 was standing at the nurse's station, which was located next to Resident 318's room). RN 8 was informed of Resident 318's request to go to the activity room. RN 8 indicated, she was not Resident 318's nurse and that Resident 318 had just been escorted back to the unit "because she wanted to come back" for an unknown reason and was then parked by the nurse's station. She further indicated, when Resident 318 was sitting near the nurse's station, she was complaining. Again, it was explained to RN 8 and other staff at nurse's station that Resident 318 wanted to return to the activity room.<br><br>An observation of Resident 318 was made on 11/15/22 at 2:53 p.m. of Resident 318 sitting in her wheelchair across from the nurse's station. Resident 318 indicated, she was still waiting for a nurse to take her down to the activity room. Resident 318 was then informed due to the time, she probably missed the card game activity, but asked if she wanted to go to the activity at 3 p.m. which was "holiday pie" to which Resident 318 responded positively. At the time, the nurse's | | | |

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| | station had 4 staff members in the nursing station. The staff at the nursing station was informed of Resident 318's request to be transported down to the activity room. Staff at the desk just looked up but did not verbally respond. Resident 318 then requested for state surveyor to stay with her until someone could escort her to the activity room. At 2:57 p.m., ED (Executive Director) and AIT (Administrator in Training) walked by and asked if some help was needed. It was explained that Resident 318 was waiting for someone to assist in taking her to the activity room. AIT then assisted Resident 318 to the activity room.<br><br>An interview with AD (Activity Director) was conducted on 11/17/22 at 4:17 p.m. She indicated, while they have attempted to assist in getting all residents interested in an activity down to the activity room, there are times when the nursing staff has needed to ensure the resident was escorted down to the activity room.<br><br>An interview with AA(Activity Assistant) 25 was conducted on 11/17/22 at 4:28 p.m. She indicated, on 11/15/22, she had gone down to Resident 318's room to ask her if she was interested in coming to the Texas Flip Em' game and Resident 318 had told her she had to wait for the nurse. AA 25 stated, she had heard from another staff member on the unit, that Resident 318 needed her catheter changed. AA 25 further indicated, Resident 318 had never made it down to the activity room for the card game that day.<br><br>An interview with Resident 318 conducted on 11/17/22 at 4:49 p.m. indicated, the situation on 11/15/22 was not the first time she had issues with getting staff to assist her to the activity room. She indicated, she doesn't let them win and keeps asking until they take her. | | | |

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| | An interview with ED conducted on 11/21/22 at 11:49 a.m. indicated, the facility does not have an Activity policy.<br><br>3.1-33(a)<br>3.1-33(b) | | | |
| F 0684 SS=D Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>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.<br>Based on interview and record review, the facility failed to ensure transportation was provided to a wound care specialist appointment for 1 of 1 residents reviewed for pressure, and to administer eye drops, as ordered by the physician, and to timely inform the physician of a significant weight gain for 1 of 5 residents reviewed for unnecessary medications . (Resident B and Resident 31)<br><br>Findings include:<br><br>1. The clinical record for Resident B was reviewed on 11/18/22 at 2:30 p.m. The diagnosis for Resident B included, but was not limited to, infection of the skin and subcutaneous tissue.<br><br>A wound specialist visit note dated 9/6/22 indicated Resident B was to be seen for a follow up appointment in 1 week. The consultation indicated "...I debrided the wound today. | F 0684 | 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>Resident B no longer resides in the facility.<br>Resident 31's physician was notified eye drops were not administered per order and of weight gain.<br><br>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken<br>Residents who have physician's orders for eye drops and those experiencing significant weight gain have the potential to be | 01/06/2023 |

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| | 155793 | A. BUILDING 00<br>B. WING | 11/22/2022 |

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| HAMILTON TRACE OF FISHERS | 11851 CUMBERLAND RD<br>FISHERS, IN 46037 |

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| | Excisional debridement of the wounds will be performed weekly as long as I feel it is medically necessary until the wound has completely granulated or the wound has healed. My expectation is that I will need to debride weekly for 16+ more weeks..."<br><br>During a confidential interview, she indicated Resident B had missed a weekly wound specialist appointment dated 9/13/22, due to transportation had not been provided.<br><br>The facility medical provider progress note dated 9/13/22 indicated "...She (Resident B) reports she was post (sic) to have a wound care appointment this morning but transportation was not arranged and so it had to be rescheduled...3) Left foot wound. Patient has IV [intravenous] antibiotics ordered through 9/21/2022 and wound VAC [vacuum-assisted closure]. Patient follows with wound care on a weekly basis. Continue local treatment per orders..."<br><br>An interview was conducted with the Nurse Consultant on 11/18/22 at 11:30 a.m. She indicated she was unable to determine why Resident B had missed the 9/13/22 wound specialist appointment.<br>2a. The clinical record for Resident 31 was reviewed on 11/15/22 at 2:42 p.m. The Resident's diagnosis included, but were not limited to, heart failure and dry eye syndrome.<br><br>A Significant Change of Status MDS (Minimum Data Set) Assessment, completed 9/20/22, indicated Resident 31 was cognitively intact. Her weight was 141 pounds and she had experienced a significant weight loss while not on a weight loss regimen.<br><br>A care plan, initiated 3/18/22, indicated she had | | affected by the alleged deficient practice and have been audited.<br><br>3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur<br>Licensed nurses have been educated regarding following physicians orders and notification of the MD for significant weight gain. Education will occur upon hire and annually.<br><br>4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place<br>DON or designee will audit 5 residents with orders for eyes drops to ensure physician's order is being followed and 5 residents with significant weight gain to ensure the physician has been notified. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee. | |

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| | dry eyes with a goal that she would state relief from her dry eyes after interventions were rendered. The interventions, initiated on 3/18/22, were to encourage fluid consumption, notify the physician or nurse practitioner if interventions were not effective, and to provide eye drops as ordered by the physician.<br><br>A physician's order, dated 7/25/22, indicated that she was to receive ocusoft lid scrub (eyelid cleanser combination 5) 1 pad twice a day to gently cleanse external eye.<br><br>A physician's order, dated 10/31/22, indicated she was to receive Refresh Celluvisc (lubricating eye drop) 1 drop to both eyes four times a day.<br><br>During an interview on 11/15/22 at 2:42 p.m., Resident 31 indicated her eyes hurt. She was observed in bed and her eyes were red and inflamed.,<br><br>The Treatment Administration Record for October and November 2022 indicated the OcuSoft Lid Scrub has been completed twice daily on all days except 10/14, 10/15, 10/16, 10/29, 11/4, 11/12, and 11/13/22. The evening treatment had been refused by the resident on these days.<br><br>The Medication Administration record for October and November 2022 indicated the Refresh Celluvisc had been administered 4 times a day.<br><br>On 11/17/22 at 10:39 a.m., the medication cart was observed with LPN (Licensed Practical Nurse) 12. The medication cart contained a box of OcuSoft Lid Scrub which was delivered to the facility on 10/24/22 and contained 30 pads. There were pads remaining in the box. A box of Refresh Celluvisc was present in the medication cart. It had been | | | |

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| | delivered to the facility on 10/28/22 and contained 30 vials. There were vials remaining in the box.<br><br>During an interview on 11/17/22 at 10:39 a.m., LPN 12 indicated that Resident 31 tolerated the eye drops pretty well and that there were no other boxes of either medication present in the facility.<br><br>During an interview on 11/17/22 at 10:52 a.m., Registered Pharmacist 13 indicated that the OcuSoft Lid Scrub pads had last been filled on 10/24/22 and that 1 box had been delivered to the facility. The box should have lasted 15 days when administered as ordered and that no other boxes had been delivered. One box of 30 vials of Refresh Celluvisc had been delivered to the facility on 10/28/22. When given 4 times a day the box should have lasted about 7 days. There had not been any other boxes of Refresh delivered to the facility.<br><br>2b. A care plan, initiated 9/23/2019, indicated she had a potential for fluid volume excess related to heart failure with a goal that she would not exhibited respiratory distress related to fluid volume excess. The interventions included, but were not limited to, assess and report for fluid excess (weight gain, increased blood pressure, shortness of breath, edema, worsening of edema) which was initiated on 9/23/2019.<br><br>The weight record for Resident 31 indicated that on 9/1/22 her weight was 140.5 pounds, on 9/16/22 her weight was 140.5 pounds, on 10/1/22 her weight was 154.9 pounds and on 11/2/22 her weight was 149.2 pounds.<br><br>A dietary progress note, dated 9/20/22 at 1:59 p.m., indicated Resident 31 had a weight loss of 12.6% in 84 days. She had a normal BMI (Body | | | |

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| | Mass Index) of 22.7. She was eating an average of 50% of her meals.<br><br>A dietary progress note, dated 10/19/22 at 3:22 p.m., indicated Resident 31 had a weight gain of 10.2% in 30 days. She had a normal for age BMI of 25. She was eating 26 to100% of her meals.<br><br>A physician progress noted, dated 10/24/22, indicated that Resident 31 had recently been off furosemide (diuretic medication) and she had gained weight and had edema (swelling) over her lower extremities had worsened. He would restart her furosemide at 20 milligrams.<br><br>During an interview on 11/17/22 at 2:52 p.m., LPN 12 indicated that due to the 14-pound weight gain between 9/16/22 and 10/1/22 she would have informed the physician or the dietician to see if a reweight was needed to assure the weight was correct and to make them aware of the weight change.<br><br>During an interview on 11/17/22 at 3:01 p.m., Registered Dietician 14 indicated that she had reviewed Resident 31's weights on 9/23/22 and 10/19/22. She had not asked for a reweight. She would have if she thought it was appropriate. She was unaware if Resident 31 had edema (swelling).<br><br>On 11/17/22 on 3:39 p.m., the Director of Nursing provided the Weight Management Policy, effective March 2015, which read "...Purpose: This policy is meant to provide guidance to the community on obtaining weights and addressing significant weight changes... If the resident has a previous weight in the medical record that weight will be compared to the current weight being obtained to ensure that a reweight is done immediately if there is a significant change in | | | |

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|---|---|---|---|---|
| | weight....If the resident weighs 101 lbs. or more and there is a weight change from the previous weight of +/- 5 lbs. then he/she will be re-weighed...Significant weight change is defined as 5% loss/gain in 30 days... Significant weight loss/ gain protocol...Family/ physician/ RD notifications will be documented in the medical record. The RD will be notified to assess/ review the resident for recommendations on his/her next visit.<br><br>This Federal tag relates to complaint IN00391026.<br><br>3.1-37(a) | | | |
| F 0689 SS=D Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, interview, and record review, the facility failed to implement fall interventions, as care planned, for 2 of 3 residents reviewed for accidents. (Residents 28 and 68)<br><br>Findings include:<br><br>1. The clinical record for Resident 28 was reviewed on 11/16/22 at 10:45 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, diabetes, and hypertension.<br><br>The 8/2/22 post fall assessment indicated she had | F 0689 | 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 28 and resident 68's fall interventions were immediately put in place during the survey.<br><br>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken | 11/22/2022 |

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| | an unwitnessed fall in her bathroom on 8/2/22 at 7:00 p.m. with an injury to her head and was transferred to the hospital after the fall.<br><br>The 8/6/22, 6:41 p.m. nurse's note read, "Resident re-admitted to facility at 2:05 p.m. on stretcher accompanied by 2 EMTs [emergency medical technicians.] Resident was at baseline, alert and verbal upon questioned by this nurse. Skin assessment completed, skin tear right upper hand measuring 3 cm X [by] 3 cm with no depth to it r/t [related to] fall and 5 staples to the laceration on posterior scalp on the right side on head, it measures 6 cm."<br><br>The 10/23/22 post fall event indicated she had an unwitnessed fall in her bathroom on 10/23/22 at 3:52 p.m. resulting in an abrasion.<br><br>An interview was conducted with Family Member 30 on 11/16/22 at 11:22 a.m. She indicated Resident 28 fell about a month ago and hurt her back. She had to lay in bed for about a week afterwards.<br><br>The 2/4/21 fall care plan, last reviewed/revised on 10/28/22, indicated she was at risk for falling and fall related injuries related to requiring assistance from staff for transfers, use of a wheel chair, incontinence, impaired cognition, receiving antihypertensive medication, hypoglycemic medication, and laxatives. An intervention was for her to have a perimeter mattress on her bed, starting 1/27/22.<br><br>An observation of Resident 28's bed was made on 11/17/22 at 10:15 a.m. She did not have a perimeter mattress on her bed. The mattress on her bed was flat all the way around it. Resident 28 was not in bed at this time. | | Residents who have experienced a fall have the potential to be affected by the alleged deficient practice and have been audited to ensure fall interventions have been implemented per the care plan.<br><br>3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur<br>Nursing associates educated to ensure fall interventions are implemented. Education will be provided upon hire and annually.<br><br>4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place<br>DON or designee will audit 5 residents to ensure fall interventions have been implemented. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee. | |

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| | An observation of Resident 28's bed was mad with UM (Unit Manager) 31 on 11/17/22 at 11:52 a.m. She indicated she was unfamiliar with what a perimeter mattress was. She stated, "This is just a flat mattress. I'll ask [Name of LPN - Licensed Practical Nurse 32.]"<br><br>An observation of Resident 28's bed was made on 11/17/22 at 11:54 a.m. with UM 31 and LPN 32. An interview was conducted with LPN 32 at this time. LPN 32 indicated Resident 28's mattress was "just a regular mattress," not a perimeter mattress. LPN 32 indicated a perimeter mattress had sides all around it that went up higher than the rest of the mattress. It was used to prevent falls. LPN 32 was unsure whether Resident 28 was supposed to have a perimeter mattress or not.<br><br>2. The clinical record for Resident 68 was reviewed on 11/15/22 at 12:05 p.m. Her diagnoses included, but were not limited to, Alzheimer's disease and hypertension.<br><br>The 21/6/20 fall care plan, last reviewed/revised on 10/26/22, indicated she was at risk for falling and fall related injuries related to requiting assistance from staff for transfers, impaired cognition, incontinence, and receiving routine antidepressant, anxiolytic, narcotic, and laxative medications. An intervention was for her to wear non-skid socks at all times when shoes were not worn.<br><br>An observation of Resident 68 was made on 11/15/22 at 12:13 p.m. She was sitting in her wheel chair in the dining room. She was wearing a pair of white tube socks. They were not non-skid socks and she was not wearing any shoes.<br><br>An observation of Resident 68 was made on | | | |

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| | 11/17/22 at 11:22 a.m. She was sitting in her wheel chair in the dining room. She was wearing a pair of white tube socks. They were not non-skid socks and she was not wearing any shoes.<br><br>An interview was conducted with CNA (Certified Nursing Assistant) 33 on 11/17/22 at 11:40 a.m. at the nurses desk. Resident 68 was visible in the dining room during this interview. CNA 33 indicated Resident 68 was totally dependent upon staff for getting dressed and that CNA 34 dressed her that morning, but CNA 33 had previously assisted her. Resident 68 usually wore gripper socks, and she should be wearing them now to help prevent falls.<br><br>An observation of Resident 33's room was made with CNA 33 on 11/17/22 at 11:42 a.m. An interview was conducted with CNA 33 at this time. CNA 33 rummaged through a sock drawer in her closet. There were no non-skid socks in the drawer. CNA 33 indicated all she saw were "regular" socks in the drawer, but she could get some non-skid socks for her.<br><br>On 11/17/22 at 11:44 a.m., CNA 33 assisted Resident 68 from the dining room into the activity room. CNA 33 removed Resident 68's white tube socks from her feet and replaced them with non-skid socks. Resident 68 did not appear bothered by the sock change.<br><br>An interview was conducted with CNA 33 on 11/17/22 at 11:49 a.m. She stated, "She was okay with it."<br><br>The Fall Prevention Policy and Procedure was provided by the DON (Director of Nursing) on 11/17/22 at 1:28 p.m. It read, "Strategies for interventions to prevent falls will be individual for | | | |

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| | each patient. Each section of the fall risk assessment tool should be considered and staff should receive education pertaining to these risk factors to reduce falls....Fall risk care plans will be kept current by the IDT [Interdisciplinary Team] and other associates within each community. Individualized interventions on the fall care plan will be duplicated onto care sheets to ensure care plan strategies are integrated into the health system."<br><br>3.1-45(a)(2) | | | |
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00391026.<br><br>Complaint IN00391026 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F684.<br><br>Survey dates: November 15, 16, 17, 18, 21 and 22, 2022<br><br>Facility number: 012644<br><br>Residential Census: 70<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on December 5, 2022 | R 0000 | The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this SOD Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review. | |
| R 0044<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(r)(1-5)<br>Residents' Right - Deficiency<br>(r) The transfer and discharge rights of | | | |

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| | residents of a facility are as follows:<br>(1) As used in this section, " interfacility transfer and discharge " means the movement of a resident to a bed outside of the licensed facility.<br>(2) As used in this section, " intrafacility transfer " means the movement of a resident to a bed within the same licensed facility.<br>(3) When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility.<br>(4) Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless:<br>(A) the transfer or discharge is necessary for the resident ' s welfare and the resident ' s needs cannot be met in the facility;<br>(B) the transfer or discharge is appropriate because the resident ' s health has improved sufficiently so that the resident no longer needs the services provided by the facility;<br>(C) the safety of individuals in the facility is endangered;<br>(D) the health of individuals in the facility would otherwise be endangered;<br>(E) the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or<br>(F) the facility ceases to operate.<br>(5) When the facility proposes to transfer or discharge a resident under any of the circumstances specified in subdivision (4)(A), (4)(B), (4)(C), (4)(D), or (4)(E), the resident ' s clinical records must be documented. The documentation must be made by the following:<br>(A) The resident ' s physician when transfer or discharge is necessary under subdivision | | | |

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| | (4)(A) or (4)(B).<br>(B) Any physician when transfer or discharge is necessary under subdivision (4)(D).<br>Based on interview and record review, the facility failed to ensure 1 of 2 residents reviewed for closed records and transfer-discharge rights had the appropriate state-mandated transfer-discharge documents completed and a copy placed in the resident's clinical record. (Resident 73)<br><br>Findings include:<br><br>The clinical record of Resident 73 was reviewed on 11-21-22 at 11:50 a.m. Her diagnoses included, but were not limited to osteoarthritis, hypertension, chronic pain, difficulty in walking and lack of coordination. It indicated she was admitted to the facility on 7-9-22.<br><br>A nursing progress note, dated 8-8-22 at 1:14 p.m., indicated Resident 73 was complaining of fatigue and not feeling well. It indicated she tested positive for Covid-19.<br><br>A nursing progress note, dated 8-9-22 at 1:26 p.m., indicated Resident 73 was found lying on the floor on her back and stated she had fallen and hit her head and was complaining of head, neck and back pain. She was sent to an area emergency room for further evaluation and treatment, upon notification to the family, physician and facility management.<br><br>In an interview with LPN 7 on 11-21-22 at 1:35 p.m., she described Resident 73 as being alert and oriented to person, place and event. She indicated the resident was on the residential portion of the building for a short time and had a fall and was then sent out to the hospital. She indicated the facility is not required to provide the | R 0044 | **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br>· State-mandated transfer-discharge documents to be completed and placed in residents' clinical records when indicated.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br>· All residents that are transferred or discharged have potential to be affected by the alleged deficient practice.<br>· Audits will be conducted by clinical managers to ensure state-mandated transfer-discharge documents are completed and placed in residents' clinical records when indicated.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>· Clinical staff to be educated on state-mandated transfer-discharge documents needing to be completed and placed in residents' clinical | 01/06/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155793 | A. BUILDING 00<br>B. WING | 11/22/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| HAMILTON TRACE OF FISHERS | 11851 CUMBERLAND RD<br>FISHERS, IN 46037 |

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| | resident any state-mandated transfer-discharge forms "that you would have to send like if you were in the LTC [certified or skilled nursing] part of the building." She indicated she did send some paperwork with the resident and called report to the receiving emergency room. LPN 7 provided copies of those documents, which included Resident 73's face sheet with demographic information, her diagnoses and a listing of her current medications.<br><br>In an interview with the Executive Director on 11-21-22 at 11:45 a.m., "We do not have any policies for our Residential portion of the building. We just follow the Residential Guidelines from the State. "I think the Unit Manager has a copy of the regs."<br><br>5.1-2(r)(1)<br>5.1-2(r)(3)<br>5.1-2(r)(4)(A)<br>5.1-2(r)(5)(A) | | records when indicated. Education will occur upon hire and annually.<br><br>**How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>· A transfer-discharge document audit will be completed weekly x 12 weeks. Then monthly until 6 consecutive audits achieve 100%. | |
| R 0045<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(r)(6-9)<br>Residents' Rights - Deficiency<br>(6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following:<br>(A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following:<br>(i) The resident.<br>(ii) A family member of the resident if known.<br>(iii) The resident ' s legal representative if known. | | | |

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| | (iv) The local long term care ombudsman program (for involuntary relocations or discharges only).<br>(v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility.<br>(vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions.<br>(vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F).<br>(B) Record the reasons in the resident ' s clinical record.<br>(C) Include in the notice the items described in subdivision (9).<br>(7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged.<br>(8) Notice may be made as soon as practicable before transfer or discharge when:<br>(A) the safety of individuals in the facility would be endangered;<br>(B) the health of individuals in the facility would be endangered;<br>(C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge;<br>(D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or<br>(E) a resident has not resided in the facility for thirty (30) days.<br>(9) For health facilities, the written notice specified in subdivision (7) must include the following: | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| | (A) The reason for transfer or discharge.<br>(B) The effective date of transfer or discharge.<br>(C) The location to which the resident is transferred or discharged.<br>(D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " .<br>(E) The name of the director and the address, telephone number, and hours of operation of the division.<br>(F) A hearing request form prescribed by the department.<br>(G) The name, address, and telephone number of the state and local long term care ombudsman.<br>(H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. | | | |
| | Based on interview and record review, the facility failed to ensure 1 of 2 residents reviewed for closed records and transfer-discharge rights had | R 0045 | **What corrective actions will be accomplished for those residents found to have been** | 01/06/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | the appropriate state-mandated transfer-discharge documents completed and a copy placed in the resident's clinical record. (Resident 73)<br><br>Findings include:<br><br>The clinical record of Resident 73 was reviewed on 11-21-22 at 11:50 a.m. Her diagnoses included, but were not limited to osteoarthritis, hypertension, chronic pain, difficulty in walking and lack of coordination. It indicated she was admitted to the facility on 7-9-22.<br><br>A nursing progress note, dated 8-8-22 at 1:14 p.m., indicated Resident 73 was complaining of fatigue and not feeling well. It indicated she tested positive for Covid-19.<br><br>A nursing progress note, dated 8-9-22 at 1:26 p.m., indicated Resident 73 was found lying on the floor on her back and stated she had fallen and hit her head and was complaining of head, neck and back pain. She was sent to an area emergency room for further evaluation and treatment, upon notification to the family, physician and facility management.<br><br>In an interview with LPN 7 on 11-21-22 at 1:35 p.m., she described Resident 73 as being alert and oriented to person, place and event. She indicated the resident was on the residential portion of the building for a short time and had a fall and was then sent out to the hospital. She indicated the facility is not required to provide the resident any state-mandated transfer-discharge forms "that you would have to send like if you were in the LTC [certified or skilled nursing] part of the building." She indicated she did send some paperwork with the resident and called report to the receiving emergency room. LPN 7 provided | | **affected by the deficient practice?**<br>· State-mandated transfer-discharge documents to be completed and placed in residents' clinical records when indicated.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br>· All residents that are transferred or discharged have potential to be affected by the alleged deficient practice.<br>· Audits will be conducted by clinical managers to ensure state-mandated transfer-discharge documents are completed and placed in residents' clinical records when indicated.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br>· Clinical staff to be educated on state-mandated transfer-discharge documents needing to be completed and placed in residents' clinical records when indicated. Education will occur upon hire and annually.<br><br>**How the corrective actions will be monitored to ensure the deficient practice will not** | |

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|---|---|---|---|
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| | copies of those documents, which included Resident 73's face sheet with demographic information, her diagnoses and a listing of her current medications.<br><br>In an interview with the Executive Director on 11-21-22 at 11:45 a.m., "We do not have any policies for our Residential portion of the building. We just follow the Residential Guidelines from the State. "I think the Unit Manager has a copy of the regs."<br><br>5.1-2(r)(6)(A)(i)<br>5.1-2(r)(6)(A)(ii)<br>5.1-2(r)(6)(A)(iii)<br>5.1-2(r)(6)(A)(iv)<br>5.1-2(r)(6)(A)(v)<br>5.1-2(r)(7)<br>5.1-2(r)(8)(D)<br>5.1-2(r)(9)(A)<br>5.1-2(r)(9)(B)<br>5.1-2(r)(9)(C)<br>5.1-2(r)(9)(D)<br>5.1-2(r)(9)(E)<br>5.1-2(r)(9)(F)<br>5.1-2(r)(9)(G) | | **recur, i.e., what quality assurance program will be put into place?**<br>· A transfer-discharge document audit will be completed weekly x 12 weeks. Then monthly until 6 consecutive audits achieve 100%. | |
| R 0091<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(h)(1-4)<br>Administration and Management - Noncompliance<br>(h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following:<br>(1) The range of services offered.<br>(2) Residents' rights.<br>(3) Personnel administration.<br>(4) Facility operations.<br>The policies shall be made available to residents upon request. | | | |

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|---|---|
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| | Based on interview, the facility failed to ensure it developed policies for the Residential portion of the facility. This deficient practice has the potential to adversely affect all 70 residents of the facility.<br><br>Findings include:<br><br>In an interview with the Executive Director on 11-21-22 at 11:45 a.m., "We do not have any policies for our Residential portion of the building. We just follow the Residential Guidelines from the State. "I think the Unit Manager has a copy of the regs."<br><br>5-1.3(h)(1)<br>5-1.3(h)(2)<br>5-1.3(h)(3)<br>5-1.3(h)(4) | R 0091 | **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>· Policies for the residential portion of the building were created and available during the survey. Staff unaware where to locate them.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br><br>·Staff have been educated where to find the residential policies.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>· Associates educated on where to locate the policies. Education will occur upon hire and annually.<br><br>**How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br><br>Policies will be reviewed at least | 01/06/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155793 | A. BUILDING 00<br>B. WING | 11/22/2022 |

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|---|---|
| HAMILTON TRACE OF FISHERS | 11851 CUMBERLAND RD<br>FISHERS, IN 46037 |

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|---|---|---|---|---|
| | | | annually for updates. | |
| R 0217<br><br>Bldg. 00 | 410 IAC 16.2-5-2(e)(1-5)<br>Evaluation - Deficiency<br>(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:<br>(1) The services offered to the individual resident shall be appropriate to the:<br>(A) scope;<br>(B) frequency;<br>(C) need; and<br>(D) preference;<br>of the resident.<br>(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.<br>(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.<br>(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.<br>(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.<br>Based on interview and record review, the facility failed to identify and document the services to be provided by the facility (a service plan) for 1 of 5 residents reviewed for record review. (Resident 29) | R 0217 | **What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** | 01/06/2023 |

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|---|---|---|---|
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|---|---|---|---|---|
| | Findings include:<br><br>A clinical record review for Resident 29 was conducted on 11/21/22 at 2:41 p.m. Resident 29 was admitted to the facility on 3/11/22. Resident 29's diagnoses included, but not limited to, fracture of left femur, neurocognitive disorder with Lewy bodies, mixed receptive-expressive language disorder, lack of coordination, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood. The clinical record did not contain a resident/resident representative signed copy of a service plan which should have contained the services offered to the individual resident including: scope; frequency; need; and preference of the resident.<br><br>An interview with NC (Nurse Consultant) was conducted on 11/22/22 at 12:48 p.m. NC indicated, Resident 29 had a care plan dated 7/15/22 and a service plan meeting in October 2022, but was unable to locate a signed service plan prior to those dates. | | · A service plan was developed for resident 29.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?**<br><br>· Residents residing in residential have the potential to be affected by the alleged deficient practice and have been audited to ensure they have service plans.<br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**<br><br>· Education provided for the residential unit manager and licensed associates regarding service plans. Education will be provided upon hire and annually.<br><br>**How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br><br>DON or designee will audit 5 residential charts to ensure the service plans are in place. Audits will occur weekly x 12 weeks. Then monthly until 6 consecutive audits achieve 100%. | |

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|---|---|---|---|
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| R 0246<br><br>Bldg. 00 | 410 IAC 16.2-5-4(e)(6)<br>Health Services - Deficiency<br>(6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.<br>Based on interview and record review, the facility failed to ensure PRN (as needed) medications administered by a QMA (qualified medication assistant) were authorized by a licensed nurse or physician prior to administration for 1 of 5 residents reviewed for record review. (Resident 29)<br><br>Findings include:<br><br>A clinical record review for Resident 29 was conducted on 11/21/22 at 2:41 p.m. Resident 29 was admitted to the facility on 3/11/22. Resident 29's diagnoses included, but not limited to, fracture of left femur, neurocognitive disorder with Lewy bodies, mixed receptive-expressive language disorder, lack of coordination, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood and migraines.<br><br>A physician's order dated 3/19/22 indicated for Resident 29 to receive two acetaminophen (Tylenol) 500 mg (milligrams) tablets once a day as needed for acute pain due to trauma.<br><br>Resident 29's September and October 2022 MAR (medication administration record) indicated the two tablets of 500 mg acetaminophen were | R 0246 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>· Nurse assessments will be conducted on all PRN medication administrations.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>· Residents receiving PRN medication have the potential to be affected by the alleged deficient practice. An audit of the last 30 days was completed to ensure a licensed nurse assessed prior to the QMA administering PRN medications.<br><br>What measures will be put into place or what systemic changes | 01/06/2023 |

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|---|---|---|---|
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|---|---|---|---|---|
| | administered by QMA 26 on the following dates and times:<br>9/7/22 at 12:24 a.m.<br>9/8/22 at 6:10 a.m.<br>9/16/22 at 5:20 a.m.<br>9/19/22 at 4:38 a.m.<br>9/20/22 at 2:41 a.m.<br>9/21/22 at 5:11 a.m.<br>9/22/22 at 7 a.m.<br>9/30/22 at 5:58 a.m.<br>10/20/22 at 1:22 a.m.<br><br>The nursing notes for Resident 29 did not indicate who/or if a licensed nurse or physician had given authorization for the PRN medication to be administered on the dates indicated.<br><br>An interview with NC (Nurse Consultant) conducted on 11/22/22 at 12:48 p.m. indicated, she was unable to identify which/or if any licensed nurse or physician had given prior authorization to administer the PRN acetaminophen medication to Resident 29. | | you will make to ensure that the deficient practice does not recur?<br><br>·Licensed nurses and QMAs educated on the proper practice of assessing before administrating a PRN medication. Education will occur upon hire and annually.<br><br>**How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>DON/Designee will review the medication administration history report to ensure appropriate documentation and assessment for PRN medications is present. Audit will occur daily x 30 days, weekly x 12 weeks, then monthly x 5 for a total of 9 months. | |
| R 0410<br><br>Bldg. 00 | 410 IAC 16.2-5-12(e)(f)(g)<br>Infection Control - Noncompliance<br>(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.<br>(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be | | | |

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| HAMILTON TRACE OF FISHERS | 11851 CUMBERLAND RD<br>FISHERS, IN 46037 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.<br>Based on interview and record review, the facility failed to ensure a tuberculin (TB) skin test was completed on new admissions within 90 days of admission to the facility and read within forty-eight to seventy-two hours of administration of the TB test for 2 of 5 residents reviewed for record review. (Residents 2 and 29)<br><br>Findings include:<br><br>1. The clinical record for Resident 2 was reviewed on 11/21/22 at 10:44 a.m. Resident 2 was admitted to the facility on 5/13/22. Under the immunizations and preventative health tab in the facility's EHR (electronic health record) for Resident 2 was one TB test listed. Upon review, the one TB test dated 5/19/22 indicated, the following:<br>Created date 5/19/22<br>Administered: "Yes- In house"<br>Type of Test: "Mantoux Skin Test"<br>Expiration date: 4/19/2023<br>Step: "Step 2"<br>Lot number: c5807aa<br>Administration Date/Time: 5/19/22; no time was indicated<br>Site: no site was indicated; left blank<br>Administered by: left blank<br>Manufacturer: not indicated; left blank<br><br>TB Test Results | R 0410 | **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**<br><br>· Resident 2 and res 29 have received the first PPDs and the second step PPDs have been scheduled.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?**<br><br>· Residents residing in the facility have the potential to be affected by the alleged practice and have been audited to ensure TB skin tests have been completed.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** | 01/06/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155793 | A. BUILDING 00<br>B. WING | 11/22/2022 |

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| | Date/Time Test was read: no indication; left blank<br>Interpretation: no indication; left blank<br>Size/Induration (mm): not indicated; left blank<br>Read by: not indicated; left blank<br>The clinical record did not indicate when or if a step 1 (one) TB test had been administered.<br><br>2. The clinical record for Resident 29 was reviewed on 11/21/22 at 2:41 p.m. Resident 2 was admitted to the facility on 3/11/22. Under the immunizations and preventative health tab in the facility's EHR (electronic health record) for Resident 29 were three TB test dates listed; 3/11/22, 3/28/22, and 11/2/22.<br>a. The TB test dated 3/11/22 indicated, the following:<br>Created date: 3/11/22<br>Type of Test: "Mantoux Skin Test<br>Expiration date: not indicated; left blank<br>Administered: "Yes- in House"<br>Step: "Step 1"<br>Lot number: not indicated; left blank<br>Administration Date/Time: not indicated; left blank<br>Site: Left Forearm<br>Administered by: not indicated; left blank<br>TB screen completed: not indicated; left blank<br>Manufacturer: not indicated; left blank<br>Administered by: not indicated; left blank<br><br>TB Test Results<br>Date/Time Test read: 3/14/22; no time was indicated<br><br>b. The TB test dated 3/28/22 indicated, the following:<br>Created date: 3/28/22<br>Type of Test: "Mantoux Skin Test"<br>Expiration date: not indicated; left blank<br>Administered: "Yes- In House" | | Licensed nurses have been educated to ensure TB skin tests have been completed for new admissions and read within 48 to 72 hours of administration. Education will be provided upon hire and annually.<br>.<br>**How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br><br>DON/designee will audit 5 new admissions to ensure TB skin tests have been completed and read within 48-72 hours of administration. Audits will be completed weekly x 12 weeks then monthly x 6 months. | |

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| | Step: "Step 2"<br>Lot number: not indicated; left blank<br>Administration Date/Time: 3/28/22; time not indicated; left blank<br>Site: "Left Forearm"<br>Administered by: not indicated; left blank<br>TB screen completed: not indicated; left blank<br>Manufacturer: not indicated; left blank<br><br>TB Results<br>Date/Time test was read: 3/28/22; no time was indicated<br><br>An interview with NC (Nurse Consultant) conducted on 11/22/22 @ 12:48 a.m. indicated, she did not know why the requested information concerning TB testing/documentation was not completely recorded.<br><br>A COVID-19 emergency Waiver, Guidance, and Emergency Orders for Residential Care Facilities from State Department of Health, 410 IAC 16.2-5-12(e), issued on 3/20/2020 indicated, residential care facilities are no longer required to complete a tuberculin skin test for residents within three (3)months prior to admission but must do so within ninety (90) days of admission. | | | |