STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155005	A. BUILDING 00 B. WING	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BEAUMONT REHABILITATION AND HEALTHCARE CENTER	1345 N MADISON AVE ANDERSON, IN 46011

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00436913, IN00436778, IN00436566, IN00436817, IN00436100, IN00435362 and IN00435861. Complaint IN00436913 - Federal/State deficiencies related to the allegations are cited at F610. Complaint IN00436778 - Federal/State deficiencies related to the allegations are cited at F610. Complaint IN00436566 - Federal/State deficiencies related to the allegations are cited at F609. Complaint IN00436817 - No deficiencies related to the allegations are cited. Complaint IN00436100 - No deficiencies related to the allegations are cited. Complaint IN00435362 - No deficiencies related to the allegations are cited. Complaint IN00435861 - No deficiencies related to the allegations are cited. Survey dates: May 24, 25, 26, 27, 28 and July 1 and 2, 2024 Facility number: 000005 Provider number: 155005 AIM number: 100270840 Census Bed Type: SNF/NF: 120 SNF: 5	F 0000	7-26-2024 IDOH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Provider number :155005 AIM number :100270840 Facility number: 000005 Re: Recertification Survey Beaumont Rehabilitation and Healthcare Center 1345 N Madison Ave Anderson, IN 46011 Survey Event ID Z46611 Dear Ms. Buroker: On July 2, 2024, a Recertification and State Licensure with Complaint (IN00435362, IN00435861, IN00436100, IN00436566, IN00436778,IN00436817, IN00436913, IN00435362, IN00435861, IN00436100, IN00436566,IN00436778, IN00436817, IN00436913) was conducted by the Division of Long-Term Care, Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Goran Pentroski	HFA	08/01/2024

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

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	Total: 125 Census Payor Type: Medicare: 7 Medicaid: 98 Other: 10 Total: 125 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 11, 2024.		Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review to confirm that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of 7-29-2024. Please feel free to call me with any further questions at 1-765-644-2888 Respectfully submitted, Goran Prentoski HFA	
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or			

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

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	allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on interview and record review, the facility failed to resolve and respond to resident	F 0585	F585 D Grievances The facility requests paper	07/29/2024

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	grievances in a timely manner for 3 of 3 residents reviewed for choices. (Residents 30, 33, and 81) Findings include: 1. During an interview on 6/26/24 at 3:31 p.m., Resident 30 indicated he went to dialysis at 5:30 a.m. on Mondays, Wednesdays, and Fridays each week. Sometimes dietary staff was not there before he left with transportation for his appointment. He was not served breakfast, nor packed a breakfast, to take with him to dialysis. Due to his lack of breakfast, he had spoken to a Cook and the current Dietary Manager (DM) week after week until approximately a month ago when he finally gave up because no one resolved his concerns. He even suggested some simple solutions such as fresh fruit like grapes and bananas. As a result, he went to dialysis without breakfast. Approximately two months ago, he spoke with the Administrator yet it was not resolved. Resident 30's clinical record was reviewed on 6/26/24 at 4:10 p.m. Diagnoses included end stage renal disease with dependence on renal dialysis and depression. A current order, dated 4/4/23, included a liberalized renal/carbohydrate controlled diet, regular texture, thin liquids consistency with large protein portions. A current order, dated 2/28/23, included dialysis treatments three times a week on Monday, Wednesday, and Friday with transportation pick up time 5:00 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 5/7/24, indicated the resident		compliance for this citation This plan of correction if the center's credible allegation of compliance. Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provision of federal and state law. 1.) Immediate action taken for those residents identified: • Dietary Services was notified regarding provision of a breakfast tray or sack breakfast to take with resident #30 for dialysis. • Dietary services were educated on the provision of meals to dialysis residents. • Residents #33 and #81 were interviewed about meal likes and dislikes. Orders were reviewed and revised as required related to diets. The care plan was updated to reflect updated dietary orders, likes and dislikes. 2.) How the facility identified other residents: • An audit was conducted of all grievances filed within the past 14 days for completion and resident or representative notification of resolution. • Any grievance found to be a	

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	was cognitively intact. Rejection of care behaviors were not exhibited during the assessment period. The resident required set up or clean up assistance for eating. A current care plan, dated 7/5/23, indicated the resident has an altered nutritional status related to increased protein needs related to end stage renal disease with dialysis and wound healing. Interventions included the following: coordinate care with the dialysis clinic as needed(7/5/23), diet as ordered, provide meals, snacks, and fluids based on the resident food preferences and physician orders (7/5/23). During an interview on 6/28/24 at 1:30 p.m., Resident 30 was seated in a wheelchair outside at the front entrance of the facility. He indicated he had recently returned from dialysis. A breakfast tray was not provided prior to going to dialysis on this date, nor a packed breakfast, and he was very tired. During an interview on 6/28/24 at 1:53 p.m., Cook 17 indicated she was the first dietary staff to arrive in the mornings. She typically arrived around 5:00 a.m., but she did not work every day. Some of the other dietary staff members, when scheduled the early shift, did not arrive until 5:30 a.m. She was familiar with Resident 30 and he met her at times on Fridays when she arrived in the morning. He had stopped at the kitchen and requested a banana before he left today for his appointment. She did not have any bananas. The resident had voiced concerns on different occasions to her regarding breakfast and that the kitchen never had any of the fruit he requested for breakfast. She had reported these concerns to the DM and expected the DM would follow up on his concerns. The resident had not said anything		concern was immediately reviewed for resolution. • Any resident had the potential to be affected. • No residents were identified to have been affected by the cited deficiency. 3.) Measures put into place/Systematic Changes: • Education to facility staff on grievance policy. • Dietary staff educated on observation of likes, dislikes, and correct dietary orders • Audit tool developed on grievance policy and thoroughness of investigation to ensure compliance. • Care plans reviewed to determine likes, dislikes and orders were reflective. 4.) How Corrective Actions will be monitored: • The Executive Director/designee is responsible for this plan of correction. • Weekly review of audits on grievances for completion within 5 days, logged correctly, resident or responsible party notification, and satisfaction of resolution has occurred. • Audits will continue weekly until 100% compliance has been met for 3 months and QA team determines that auditing can be decreased to monthly. • All findings of concern will be immediately addressed and reported to QAPI committee	

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	else to her about his concerns regarding breakfast in about a month, so she assumed his concerns were resolved. At times, the resident was gone for his dialysis appointment before the dietary staff arrived. On those days, he had not been served a breakfast. A long time ago, she thought it had been over a year, the evening dietary staff prepared a meal tray for him and put it in the refrigerator on the unit so he could have breakfast before he went to dialysis. When they went to a contracted meal service, they discontinued making those trays in the evening. They had not corrected all the concerns the contracted service had changed. She thought they needed to resume making those meal trays in the evening so the resident would have a meal in the unit refrigerator before he left for his early appointments. During an interview on 6/28/24, at 2:10 p.m., the DM indicated he was not aware of any days the resident was not able to get breakfast. Staff had not reported to him when they did not have the items the resident requested for breakfast. He had not completed a grievance for the resident's concerns. Concerns for preferences would not warrant a grievance, but a grievance was necessary if a resident did not receive their meals. During an interview on 7/2/24 at 12:36 p.m., CNA 21 indicated she was familiar with Resident 30's care. The resident typically ate 100% of his breakfast on the days he did not have dialysis. 2. During an interview on 6/24/25 at 4:26 p.m., Resident 33 indicated the dietary staff kept serving her items from her "dislikes list" to include carrots, rice, and oatmeal. This happened on a frequent basis even though she had reported this to staff. When a dietary item was sent back, it took a long time to get a replacement back. She		monthly for further review and instruction. 5.) Date of Correction: 7-29-2024	

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	had received oatmeal on her tray several times in just the last few days. During an observation on 6/27/24 at 1:30 p.m., the resident was sitting on her bed with her meal tray in front of her on her overbed table. The meal card on her tray listed the following dislikes: rice, carrots, and oatmeal. Resident 33's clinical record was reviewed on 6/27/24 at 5:17 p.m. She admitted to the facility on 5/4/24. Diagnoses included heart failure, chronic obstructive pulmonary disease, and depression. An admission MDS assessment, dated 5/17/24, indicated the resident was cognitively intact. The resident required set- up assistance from staff for eating. The clinical record lacked a care plan for preferences and dislikes. Review of the grievance forms/ logs lacked any indication the resident had any grievances completed for receiving dietary items frequently on her dislikes list. During an interview on 6/28/24, at 10:08 a.m., Resident 33 indicated she had reported her concerns about getting her dislikes served on her meal tray to several female nurses, but she did not know their names because the nurses rotated frequently. The facility had not followed up with her to let her know what was being done to correct her concern regarding the regular receipt of dislikes on her meal tray. During an interview on 6/28/24 at 10:54 a.m., CNA 14 indicated Resident 33 had reported concerns that she had received oatmeal on her tray on			

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	multiple occasions. He had reported these concerns to the dietary staff and also reported to the ADON a couple of weeks ago. The resident was still getting the oatmeal intermittently on her meal tray in the mornings. He tried to intercept and correct the issue himself when he was on duty, but he did not work every day. During an interview on 7/2/24 at 11:57 a.m., the ADON indicated staff had not reported any concerns to her regarding regular receipt of dislikes on their dietary tray. No one reported to her, but she heard there was a problem with some residents not getting the large portion sizes as ordered. Staff usually wrote down and reported dietary concerns to the dietary staff. Concerns may be reported to any staff member and should have been placed through the grievance process for resolution when the concerns were made known. During an interview on 7/2/24 at 12:16 p.m., the SSD indicated she recalled a resident had concerns related to getting hot cereal on their tray rather than cold cereal. She could not recall which resident reported this concern or the date. It had been since January, not recently. On most occasions she would have put this through the grievance process. Lack of placing these concerns in the grievance process prevented a tracking method for resolution. No staff or residents had reported concerns with portion sizes or failure to receive breakfast prior to dialysis to her. Concerns could have been reported to any staff, but the SSD was responsible for tracking all grievances. The department manager in which the grievance was issued completed the initial follow-up with the person who reported the concern. The SSD was required to complete the final resolution with the date and			

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	time when the resolution/satisfaction was reviewed with the resident on the grievance form. These were not always completed. 3. During an interview on 6/24/24 at 3:17 p.m., Resident 81 indicated her only concern was the repetitive receipt of her dietary dislikes that were listed on her meal card, and a lack of large portions for her meals. Her meal card clearly listed her dislikes of asparagus, beans, fish, and pears, as well as need for large portions. The list was disregarded or not read when they filled the meal trays. She had received fish, beans, and pears on a regular basis (when it was on the menu) and got small portions at least three days every week. She had fish every day it was on the menu except once in the last month. She had what appeared to be a teaspoon of mixed vegetables. Sometimes when she asked for more, it was because she got small portions, but the facility wouldn't have any more food to offer her. She had reported the portion size and dietary dislike concerns to multiple aides who delivered her meals over the last couple of months. She had also reported it to the the SSD approximately one month ago. Resident 81's clinical record was reviewed on 6/26/24 at 4:18 p.m.. Diagnosis included chronic obstructive pulmonary disease. A current physician order, dated 1/18/24, included large protein portions with meals to aid in wound healing. A quarterly MDS assessment, dated 4/19/24, indicated the resident was cognitively intact. She required set- up assistance for eating. A current care plan, dated 1/18/24, indicated the resident had altered nutritional status and an			

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	increased protein needs related to chronic obstructive pulmonary disease. Interventions included large protein portions with meals (1/18/24) and provide meals, snacks, and fluids based on the residents food preferences and physician orders (1/18/24). During an interview on 6/28/24 at 1:11 p.m., the resident's meal tray was delivered. The meal tray contained one and one half cheeseburgers on her tray. She indicated she had never received large protein portions when she received a sandwich until today. The portion sizes she found on her meal tray on this date was great. She had reported her dietary concerns to any staff she thought would listen to her without success. She had even reported it to the SSD approximately one month ago, but no one had responded to her concerns with a plan for resolution. During an interview on 6/28/24 at 1:36 p.m., CNA 15 indicated, approximately three weeks ago, Resident 81 reported concerns due to a lack of large portions sizes. During that time, she was able to get her additional food. She did not typically have time to write out the grievance forms but she reported concerns verbally to the nurse, unit manager, and the SSD. Review of facility grievances lacked indication of the concern related to portion sizes. During an interview on 6/28/24 at 4:11 p.m. , CNA 19 indicated residents on the intermediate units frequently received dislikes on their meal trays. Running to the kitchen delayed the aides to complete their tasks such as passing other meal trays and providing care. Staff who had concerns reported to them should have completed a grievance form or reported the concern to the			

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	Administrator so he could complete the grievance form. During an interview on 6/28/24 at 3:23 p.m., the SSD indicated the grievance log contained all facility grievances, completed and unresolved, from 1/1/24 to 6/28/24. During an interview on 7/2/24 at 2:19 p.m., the SSD indicated she had reviewed the grievance log and did not have any grievances of her own or any provided to her regarding the above mentioned concerns that were reported to staff members. A current, undated, facility policy titled "Grievances and Concerns," provided by the DON on 7/1/24 at 11:29 a.m., indicated the following: "...Policy... It is the Policy of this Facility to thoroughly investigate all Resident and family grievances/concerns including but not limited to his/her treatment, medical care... etc. The resident/family has a right to file a grievance and can do so without fear of reprisal or mistreatment. Procedure: ... 2. Any staff member may assist a Resident or family member in completing the Facility form. 3. Completed Grievance/Concern Forms will be given to the Social Service Department. The Social Service Department will route the Grievance/Concern Form to the appropriate department within 24-48 hours. 4. A prompt investigations will be completed and documented by the appropriate staff member on the facility's Grievance/Concern Form... 6. The Social Service Director will be responsible for logging all Resident and family Grievances in the Facility Grievance Log. 7. Within 5 working days of the date the Grievance/Concern Form was filed, the Resident and/or family member shall be informed orally of the results of the investigation. Copies of the			

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	completed Grievance/Concern Form may be given to Residents and/or family members as deemed appropriate by the Facility management...." 3.1-7(a)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility	F 0609	F 609 D Reporting of Alleged	07/29/2024

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	155005	A. BUILDING 00 B. WING	07/02/2024

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	failed to report an allegation of resident abuse to the Indiana State Department of Health (IDOH) for 1 of 4 residents reviewed for allegations of abuse. (Resident C) Finding includes: Resident C's clinical record was reviewed on 6/26/24 at 9:06 a.m. Current diagnosis included anxiety, depression, and dementia. A 4/24/24, significant change, Minimum Data Set Assessment (MDS) indicated the resident was severely cognitively impaired, wandered daily during the assessment period, and did not reject care during the assessment period. A 6/6/24 Nursing Note, signed by RN 22, indicated on 6/6/24 at 5:35 a.m.,Resident C had experienced a confusing night. The resident had been observed walking down the hall with no clothes on. RN 22 got the resident dressed Resident C was standing in their room attempting to to walk through the wall. The resident was hard to redirect, but the writer was able to get them to the side of the bed. The writer had to pull the back of the resident's pants to guide her to the bed to sit down before falling. The writer laid the resident down. Resident C was a two person assist, but the aide did not assist. A facility "Grievance/Complaint Resolution Report," dated 6/6/24, indicated CNA 23 had filed a concern regarding RN 22 being rough with Resident C during care. The five documented staff interviews that accompanied the investigation of the grievance/complaint form all consisted of the same question, "Have you ever witnessed or heard about [RN 22's name] abusing residents."		Violations The facility respectively requests a desk review for this citation. Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. The Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements 1. Immediate actions taken for those residents identified: • A complete and thorough investigation was completed related to the allegation regarding resident C. • No adverse actions were identified. 2. How the facility identified other residents: • Current residents have the potential to be affected. • No other resident was identified to have been affected. • Audit conducted of last 14 days of grievances to determine if concerns or allegations of abuse existed. • None were identified. • Interviews with staff and residents did not reveal any concerns or further allegations 3. Measures put into place/ System changes:	

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	During an interview on 6/28/24 at 9:00 a.m., the Administrator indicated he had not reported the 6/6/24 grievance concern to IDOH as an allegation of abuse. The reporting CNA had indicated the RN held down the residents hands when she resisted care. The Administrator felt "abuse" and "rough handling" were just a matter of verbiage. The nurse was always a good nurse, and after the Administrator looked into the situation, he didn't report to IDOH because he didn't think it was abuse. During an interview on 7/2/24 at 10:20 a.m., CNA 23 indicated she had reported an allegation of abuse to the Administrator on 6/6/24. She had been concerned regarding RN 22's treatment of Resident C. She had informed the Administrator that RN 22 had yelled at the resident, grabbed her arm, pulled her by the back of her pants, and swung her forcefully to the bed. The resident fell to the bed very hard. The resident started crying and RN 22 cursed at her about being a "cry baby." She had also given the Administrator a written statement of her allegation. She was making an allegation of abuse when she notified the Administrator. She felt she had witnessed abuse because the nurse had yelled at the resident to sit down, grabbed her arm, swung her forcefully but the back of her pants, caused her to fall hard unto the bed and cry, then cursed her for being a cry baby. She believed there was no confusion that she was alleging abuse. During an interview on 7/2/24 at 11:25 a.m., the Administrator indicated he had never received a written statement from CNA 23 regarding the 6/6/24 allegation with Resident C. When the CNA called, she did say abuse. After he (the Administrator) talked to the CNA, he decided it		• Facility education completed on policy and procedure Abuse and Incident Reporting to IDOH. • All potential allegations will be reported to the RDO and RNC for review to ensure a thorough investigation has been initiated and conducted. • Events will be reported per reporting guidelines. • Review of the 24-hour report and grievances during scheduled IDT meetings to identify reportable events. • Issues identified will be immediately addressed with additional education and or disciplinary action. 4. How the corrective actions will be monitored: • The responsible party for this plan of correction is the Executive Director/Director of Nursing/designee. • Events will be audited and reviewed daily during morning/clinical meetings via the IDT team to review the 24-hour report to determine if anything had occurred that may meet the reporting requirements. • Facility staff will immediately notify the Executive Director should an event occur that requires or may require reporting. • Identified areas of concern will be reported per guidelines and additional education provided as required.	

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	wasn't abuse. CNA 23 had never voiced an allegation to him regarding pulling the resident by the back of her pants and her falling to the bed or the nurse yelling or pulling her arm. During an interview on 7/2/24 at 2:24 p.m., RN 22 indicated she had been informed that an employee had alleged she had abused Resident C around 6/6/24. She didn't remember the exact allegation. She did speak to the Administrator about the allegation. She thought it was about flailing arms during care. There may have been a second allegation too. She didn't remember. A current, 5/12/23, facility policy titled, "Abuse and Incident Reporting to IDOH" , which was provided by the DON on 7/1/24 at 10:55 a.m., indicated the following: "It is the policy of this facility to report and submit abuse and incidents to the Indiana State Department of Health in compliance with federal regulations...Time frames for reporting: Immediately, but no later than 2 hours-suspicion of a crime with serious bodily injury or allegations of abuse." This citation relates to complaint IN00436566. 3.1-28(c)		• Staff will be educated on abuse upon hire, annually and as needed with a focus on reporting requirements. • Audits will continue 5 times weekly for 6 months and or until 100% compliance has been achieved for 3 consecutive months, at which time the QA committee will review to identify any trends or patterns and make recommendations to revise the plan of correction. 5. Date of Correction 7-29-2024	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while			

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	the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to develop and implement a safety plan (regarding 15 minute monitoring checks) to prevent resident to resident abuse for a resident with a diagnosis of dementia and a history of intrusive wandering. This deficient practice resulted in the resident being hit in the face, choked, and relocated to a new dementia unit. (Resident E) Finding includes: Review of a 6/14/24 facility reported incident indicated the following: During an resident to resident event on 6/14/24, Resident E wandered into Resident F's room and was going through Resident F's belongings. Resident F "popped" Resident E in the mouth several times, resulting in Resident E having a red chin and a little cut on his lip. Both resident's had dementia and resided on a secured dementia unit. On 6/14/24, following the event, the facility implemented the preventative measures of separating the residents, Social Services spoke with Resident F about not hitting, and Resident E was placed on 15- minute checks. Review of a 6/15/24 facility reported incident indicated the following: Resident F reported he had put his hands around Resident E's neck because he had entered his room and was going	F 0610	F 610D Investigate/Prevent/Correct Alleged Violation The facility respectively requests a desk review for this citation. Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements 1. Immediate actions taken for those residents identified: • Resident E was assessed per psyche NP, orders were reviewed, labs were ordered, care plan was updated to reflect safety interventions. • No further events have occurred 2. How the facility identified other residents: • Current residents have the potential to be affected. • No other resident was identified	07/29/2024

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	through his belongings. Following the event, the facility had implemented these preventative measures of the residents were kept apart and Resident E was moved to the other dementia care unit within the same facility. During a confidential interview, it was indicated Resident E had recently been involved in two resident to resident altercations within a 24-hour period of time. The first event had occurred on 6/14/24. Resident E had wandered into another resident's room and was touching the other residents belongings. The other resident had hit Resident E in the face and busted his lip. Resident E had a history of roaming into others rooms. The facility was aware he had this behavior. To protect Resident E from future harm, the facility indicated they would put Resident E on 15-minute checks for his own safety. One day later, Resident E had once again entered the same resident's room and this time the other resident attempted to choke him. They did not know how this could have happened if the resident was on 15-minute checks. They did not feel the 15-minute checks were completed. After the second event, the facility decided Resident E needed to be moved to the other dementia unit for his own safety. Resident E had resided in the same unit for over a year and it was all he knew. The move felt like a punishment to the resident; he had to move when it was the other resident was aggressive. Since the move to the new unit, the resident had been in two different rooms, which was unsettling to the resident. During an observation on 6/24/24 at 2:20 p.m., Resident E was in the dining/activity room walking and touching furniture. During an observation on 6/26/24 at 10:41 a.m., the		to have been affected. 3. Measures put into place/ System changes: • Education was provided on Investigating, Preventing, and Correcting Alleged Violations and components of F610. • Education provided on de-escalating and prevention of resident-to-resident altercations. • All potential allegations will be reported to the RDO and RNC immediately for review to ensure a thorough investigation has been initiated and conducted. • Events will be reported per reporting guidelines. • Issues identified will be immediately addressed with additional education and or disciplinary action. 4. How the corrective actions will be monitored: • The responsible party for this plan of correction is the Executive Director/Director of Nursing/designee. • Events will be audited and reviewed daily during morning/clinical meetings via the IDT team to review the 24-hour report to determine if any events may have occurred • Facility staff will immediately notify the Executive Director should an event occur that requires or may require reporting. • Identified areas of concern will be	

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	resident was seated at a table in the dining/activity area. During an observation on 6/27/29 at 9:50 a.m., the resident was seated away from the activity occurring in the dining activity area. During an observation on 6/27/29 at 2:20 p.m., the resident was seated in a recliner in the TV lounge with his feet up. Resident's E's clinical record was reviewed on 6/26/24 at 9:27 a.m. Current diagnoses included dementia, anxiety, depression and Alzheimer's disease. The resident resided on the secured dementia unit. The clinical record lacked indication of 15-minute monitoring checks as part of the facility's "preventative measures" implemented following the 6/14/24 resident to resident altercation. A 5/9/24, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired and wandered daily during the assessment period. A 2/7/24, annual, most current full, MDS indicated the resident was severely cognitively impaired and wandered daily during the assessment period. The resident had a current care plan problem/need related to "resident will rummage thru other residents belongings" and the resident had behaviors of agitation, wandering, and taking others belonging. This problem originated 9/19/2023. Approaches to this problem included attempt to redirect resident when exhibiting behaviors, and redirect resident as necessary. The resident had a current care plan problem/need		reported per guidelines and additional education provided as required. • Staff will be educated on abuse upon hire, annually and as needed with a focus on reporting requirements. • Audits will continue 5 times weekly for 6 months and or until 100% compliance has been achieved for 3 consecutive months, at which time the QA committee will review to identify any trends or patterns and make recommendations to revise the plan of correction. 5. Date of Correction 7-29-2024	

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	regarding being at risk for impaired safety. Approaches to this problem included distract resident when wandering. A 6/6/2024 at 11:38 a.m. Nurses Note indicated the resident was roaming in hallways and into others rooms per his baseline and was easily redirected. A 6/12/2024 at 11:22 a.m. Nurses Note indicated the resident continued to roam in and out of rooms, and take items and put them in other rooms or in his pants. A 6/14/2024 at 1:54 p.m. Nurses Note indicated the resident was seen by another resident going through there belongings in the closet. The resident was then hit on the left side of his chin and lip was busted by another resident. The two residents were separated at time of report. The physician and family were notified of the situation. A 6/15/2024 at 8:10 p.m. Nurses Note indicated the resident had a poor interaction with another resident when the other resident reported that he put his hands around Resident E's throat, because this resident was rifling thru the other residents belongings. The residents were immediately separated and Resident E initially rated his pain 2/10 on a [pain] scale, but after a few minutes was reassessed and his pain rating was zero. This resident was moved to the other locked unit to prevent any further interactions between the two residents. A 6/18/2024 at 11:25 a.m. Nurses Note indicated the resident continued to wander in and out of rooms on the new unit. A 6/19/2024 at 12:39 a.m., Nurses Note indicated			

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	the resident continued to wander in and out of rooms and was not able to be redirected. The resident was placed in another room for the night. A 6/19/2024 at 11:32 a.m., Social Services Late Entry Note indicated the resident was again moved to a different room. During an interview on 6/27/24 at 9:41 a.m., CNA 25 indicated she had never monitored Resident E on a 15-minute checking schedule. During an interview on 6/27/24 at 9:42 a.m., QMA 26 indicated she had never monitored Resident E on 15-minute checking schedule. During an interview on 6/27/24 at 11:40 a.m., the DON indicated Resident E was not placed on 15-minute monitoring following the 6/14/24 resident to resident altercation. During an interview on 6/27/24 at 3:03 p.m., QMA 29 indicated Resident E wandered and entered other resident's rooms. A current, 2/29/21, facility policy titled "Behavior Crisis," provided by Corporate Nursing Consultant 7 on 6/28/24 at 1:00 p.m., indicated the following: "...Behavior Crisis: is defined as a situation in which the resident is considered to be a significant danger to self or others. The crisis may or may not have been exhibited in the past... 1. Implement measures to provide safety to residents and others as pertinent..." A current, 5/12/23, facility policy titled "Abuse and Incident Reporting to IDOH," provided by the DON on 7/1/24 at 10:55 a.m., indicated the following:			

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	"...Instructions for Submitting an Incident Report... i. Preventive measure taken while the investigation is in process...Interventions implemented or corrective action plan...." This citation relates to complaint IN00436913 and IN00436778. 3.1-28(d)			
F 0638 SS=D Bldg. 00	483.20(c) Qrtly Assessment at Least Every 3 Months §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. Based on record review and interview, the facility failed to ensure timely completion of Quarterly Minimum Data Set (MDS) assessments every three months for 4 of 4 reviewed for timely assessment. (Residents 22, 35, 60, 73) Findings include: 1. Resident 22's clinical record was reviewed on 6/26/24 at 1:05 p.m. Current diagnosis included left sided hemiplegia following a cerebral infarction, major depressive disorder, and repeated falls. The resident had a Quarterly MDS assessment, with the Assessment Reference Date (ARD) of 11/11/23 which was completed on 11/29/23. The assessment was completed 4 days late. The resident had a Quarterly MDS assessment, with the ARD of 5/10/24 which was completed on 5/27/24. The assessment was completed 3 days late.	F 0638	F638 D Quarterly Assessment At Least Every 3 Months The facility respectively requests a desk review for this citation Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. Immediate action taken for those residents identified: • It is the practice of this facility to follow the guidelines of the RAI manual for MDS scheduling and timely completion of the MDS. Residents #22, #35, #60, and #73 are currently in compliance.	07/29/2024

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	2. Resident 35's clinical record was reviewed on 6/28/24 at 10:05 a.m. Current diagnosis included hypertension, chronic obstructive pulmonary disease, and bipolar disorder. The resident had a Quarterly MDS assessment, with the ARD of 5/15/24 which was completed on 6/10/24. The assessment was completed 11 days late. 3. Resident 60's clinical record was reviewed on 6/26/24 at 2:15 p.m. Current diagnosis include chronic obstructive pulmonary disease, spinal stenosis, and chronic pain. The resident had a Quarterly MDS assessment, with the ARD of 11/28/23 which was completed on 12/18/23. This assessment was completed 5 days late. The resident had a Quarterly MDS assessment, with the ARD of 2/28/24 which was completed on 3/22/24. This assessment was completed 1 day late. 4. Resident 73's clinical record was reviewed on 6/27/24 at 1:08 p.m. Current diagnosis included chronic obstructive pulmonary disease, atrial fibrillation, and emphysema. The resident had a Quarterly MDS assessment, with the ARD of 5/15/24 which was completed on 6/10/24. This assessment was completed 13 days late. During an interview, on 6/27/24 at 2:53 p.m., the MDS Coordinator indicated her team utilized the Resident Assessment Instrument (RAI) manual online for properly managing the MDS tasks. The work was split up between herself and a		2. How the facility identified other residents: • Facility audit of MDS to assure compliance and within correct timeframes. 3. Measures put into place/Systemic changes: • Education provided to MDS coordinators on the scheduling and timely completion of the MDS following the RAI manual. 4. How the corrective action will be monitored: • The MDS will audit the PCC schedule monthly for 6 months to ensure that the MDS are scheduled according to RAI guidelines. • Any identified issues will be corrected upon discovery. • Results of audits will be reported to QAPI and the team will make recommendations to amend the plan of correction • The DON is responsible for overall compliance with Administrator oversight. 5. Date of correction 7-9-2024	

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	co-worker. She indicated the above listed assessments were completed late. According to the current RAI manual, retrieved from https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf, on 7/3/24 at 10:01 a.m., indicated the following: "... The Quarterly MDS completion date must be no later than 14 days after the assessment reference date (ARD)..." 3.1-31(d)(3)			
F 0640 SS=D Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record			

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	155005	A. BUILDING 00 B. WING	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BEAUMONT REHABILITATION AND HEALTHCARE CENTER	1345 N MADISON AVE ANDERSON, IN 46011

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	layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.			
	Based on record review and interview, the facility failed to ensure timely submission of Minimum Data Set (MDS) assessments for 1 of 1 resident reviewed for assessment submission. (Resident 104) Findings include: Resident 104's closed clinical record was reviewed on 6/26/24 at 10:43 a.m. Clinical diagnosis included	F 0640	F640 D Encoding/Transmitting Resident Assessments The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement	07/29/2024

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	sepsis, congestive heart failure, and diabetes mellitus. The clinical record indicated the resident discharged from the facility on 4/4/24. The resident had a Discharge MDS assessment with the Assessment Reference Date (ARD) of 4/4/24, which was completed on 4/18/24. This assessment was completed on time, but electronically transmitted for submission on 6/24/24. The assessment was transmitted 68 days late. During an interview, on 6/27/24 at 2:53 p.m., the MDS Coordinator indicated the assessment transmission task was split between herself and her offsite corporate consultant. This discharge assessment was missed in error during the transmission process. Once this error was discovered, the assessment was transmitted electronically immediately. She utilized the online Resident Assessment Instrument (RAI) manual for guidance as the MDS Coordinator. Review of the current the RAI manual, retrieved from https://www.cms.gov/files/document/finalmds-30-rai-manual-v11811october2023.pdf, on 7/3/24 at 10:01 a.m., indicated the following: "... The Discharge assessment transmission date is no later than the MDS completion date plus 14 days...."		by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: • Resident 104 no longer resides within the facility. • A discharge assessment was completed and transmitted. 2) How the facility identified other residents: • Audit of discharged residents in the previous 6 months was conducted to ensure compliance 3) Measures put into place/ System changes: • Education provided to the MDS Coordinators on transmission of data via the RAI manual in the format specified by the State and approved by CMS 4) How the corrective actions will be monitored: • MDS Tracking and Transmission Worksheet will be reviewed weekly for 6 months to ensure compliance and a summary report will b included and reviewed at the monthly QAPI meeting 5) Date of compliance: 7-29-2024	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans			

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	§483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on interview and record review, the facility failed to schedule, hold, and invite resident representatives to care plan meetings, held in conjunction with the assessment process for 3 of 4 residents reviewed for the provision of care plan meetings. (Residents E, F, & 92) Findings include: During a confidential interview with a resident representative, the representative indicated they were the party who was responsible for decision	F 0657	F657 D Care Timing and Revision The facility requests paper compliance for this citation This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The	07/29/2024

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	making and direction of the resident's care. The resident did not make independent decisions. The facility had not held a care plan meeting thus far in 2024. Their resident resided on one of the two secured dementia units. 1. Resident F's clinical record was reviewed on 6/26/24 at 9:34 a.m. Current diagnoses included dementia, anxiety, and psychotic mood disturbance. The resident resided on a secured dementia unit. The resident had an annual Minimum Date Set (MDS) assessment completed on 5/23/24. The resident also had a quarterly MDS assessment completed on 3/22/24. The resident additionally had a quarterly MDS assessment completed on 12/21/23. The clinical record indicated the most current care plan meeting was held on 6/21/23. The clinical record lacked documentation of a care plan meeting held in conjunction with the 5/23/24, 3/22/24, and 12/21/23 assessments. 2. Resident 92's clinical record was reviewed on 6/26/24 at 9:39 a.m. Current diagnoses included delusional disorder, dementia, and anxiety. The resident resided on the secured dementia unit. The resident had a quarterly MDS assessment completed on 5/30/24. The resident also had a quarterly MDS assessment completed on 2/28/24. The clinical record indicated the most current care plan meeting was held on 1/12/24. The clinical record lacked documentation of a care plan meeting held in conjunction with 5/30/24 and 2/28/24 assessments. 3. Resident's E's clinical record was reviewed on		plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: • Identified resident E, F, & #92 were assessed, and the care plan meetings were scheduled, and representatives were invited. • Care plans were reviewed and revised appropriately. 2) How the facility identified other residents: • Any resident had the potential to be affected, however none were identified to have been negatively impacted. • Care plan meetings will be held in conjunction with assessments. 3) Measures put into place/ System changes: • In-service conducted for the interdisciplinary team to review scheduling and invitations to resident’s representatives for participation in the care plan meetings. • Resident care plans will be reviewed/updated on admission, readmission, change of condition, quarterly and annually. • Notation will be placed in residents clinical record if the resident and their representative is determined not practicable for the development of the resident’s care plan. 4) How the corrective actions will be monitored:	

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	6/26/24 at 9:27 a.m. Current diagnoses included dementia, anxiety, depression and Alzheimer's disease. The resident resided on the secured dementia unit. The resident had a quarterly MDS assessment completed on 5/9/24. The resident also had a quarterly MDS assessment completed on 2/7/24. The clinical record indicated the most current care plan meeting was held on 1/18/24. The clinical record lacked documentation of a care plan meeting held in conjunction with 5/9/24 and 2/7/24 assessments. During an interview on 7/1/24 at 9:08 a.m., the Dementia Unit Manager indicated he was the individual responsible for scheduling, inviting, and leading care plan meets for residents who resided on the secured dementia units. There had been difficulties scheduling and holding care plan meetings due to the new frequency of the MDS assessments. He did not have any information regarding care plan meetings since January 2024 for Residents E, F and 92. These three residents had not had formal care plan meetings since January 2024 or prior. A current, undated, facility policy titled "Care Plans Protocol," provided by the DON on 7/1/24 at 9:56 a.m., indicated Care Plan meeting will be held within 7 days of the completion date [MDS]... Meetings will occur on set day and time (no excuse for not having a care plan meeting). 3.1-35(c)(1)		• The Director of Nursing /designee will randomly review 5 residents 'care plan records weekly ensuring that resident representatives have been invited to the care plan meeting. • Documentation will reflect invitation to resident representative to attend care plan meeting. • Any issues identified will be immediately addressed. • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months at which time the IDT can make recommendations to the plan of care. 5) Date of compliance: 7-29-2024	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care			

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	Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure the completion of physician ordered wound care treatments to promote healing of an abrasion for 1 of 2 residents reviewed for skin conditions. (Resident 83) Finding includes: Resident 83's clinical record was reviewed on 6/27/24 at 10:22 a.m. Diagnoses included an abrasion of the left foot, subsequent encounter, weakness, and unsteadiness on feet. A physician's order, dated 6/5/25, indicated to clean with Dakins (wound cleanser), apply collagen (wound treatment) to open area, and cover with foam and secure with elastic bandage to left outer foot topically every evening shift for wound healing. This order was discontinued on 6/12/24. A current physician order, dated 6/25/24, indicated to cleanse the left outer foot with Dakins (wound cleanser), apply collagen (wound treatment) to the open area and skin preparation to the tissue surrounding the wound, secure with bordered dressing every night shift on Tuesdays, Thursdays, and Saturdays for wound healing and as needed for soilage or displacement. Review of the treatment administration record for	F 0684	F 684 D Quality of Care The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.) Immediate actions taken for those residents identified: • Resident #83 was assessed, orders and plan of care reviewed and revised with interventions updated to reflect wound care treatments. 2) How the facility identified other residents: • A facility audit was completed on those residents receiving wound care treatments to determine completion. 3) Measures put into place/ System changes:	07/29/2024

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	June 2024 lacked completion of wound treatments for the resident on the following dates and shifts: a. 6/5/24 - evening b. 6/7/24 - evening c. 6/9/24 - evening d. 6/10/24 - evening e. 6/14/24 - night shift The clinical record lacked indication why the resident's left lateral foot abrasion treatments were not completed. A quarterly Minimum Data Set, dated 3/13/24, indicated the resident was cognitively intact. She used a wheelchair for mobility. The resident required moderate assistance for toileting and limited assistance for transfers. Skin conditions included a foot infection. A current care plan, dated 7/14/23, indicated the resident was at risk for impaired skin integrity with a left outer foot abrasion. Interventions included the following: treatment per physician orders (1/12/24) and wound consult as needed (1/12/24). A wound assessment, dated 2/17/24, indicated the left outer foot- abrasion full thickness measured 1.5 centimeters (cm) length (L) by 2 cm width (W) x 0.1 cm depth (D) with moderate drainage. A wound assessment, dated 6/25/24, indicated the left outer foot abrasion measured 1 cm L by 1 cm W by 0.5 cm D with moderate drainage. During a wound observation on 6/27/24 at 3:39 p.m., accompanied by LPN 12, Resident 83 had a wound to the left lateral foot, which was open and slightly smaller than the tip of an eraser. The size of the wound was consistent with the recent		• Licensed Nursing staff were educated on physician orders, skin and wound treatment completion. • Those residents identified to have skin areas will be reviewed during routine weekly wound rounds per wound nurse and Wound NP. • New orders will be immediately implemented. • TAR will be reviewed during routine clinical meetings and concerns discussed with DON/designee for correction 4) How the corrective actions will be monitored: • Director of Nursing/designee is the responsible party for this Plan of Correction with Executive Director oversight. • The Director of Nursing will randomly audit three residents treatment records weekly to ensure that treatments have been completed, care plans are reflective and orders are present. • Identified areas of concern will be addressed promptly • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	wound assessment. A small amount of serous drainage was noted on the removed dressing. During an interview with the resident, she indicated the abrasion was due to her running over her own foot with a wheelchair. During an interview on 6/28/24 at 3:58 p.m., LPN 18 indicated documentation should not have been left blank on several shifts in the treatment administrator record (TAR). Wound treatments should have been completed as ordered. There was no way to show the treatment had been administered when it was left blank. During an interview on 6/28/24 at 4:50 p.m., the DON indicated treatment/wound care orders should have been completed as ordered by the physician to promote healing of a wound. A current facility policy, dated 12/1/23 and titled "Physician Services and Orders," provided by Corporate Nurse Consultant 7 on 7/1/24 at 3:07 p.m., indicated the following: "...POLICY: It is the policy of the facility to ensure that the medical care of each resident is supervised by a physician. The facility will provide care and services related to physician services in accordance with State and Federal regulations. PROCEDURE: ... 11. All physician orders will be followed as prescribed and if not followed, the reason shall be recorded in the the resident's medical record during that shift...." 3.1-37(a)		5.) Date of compliance: 7-29-2024	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.			

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	Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide wound care treatment and care as ordered to promote healing of a pressure injury for 1 of 3 residents reviewed for pressure injuries. (Resident 70) Finding includes: Resident 70's clinical record was reviewed on 6/26/24 at 4:20 p.m. Diagnoses included unspecified atrial fibrillation, weakness, chronic pain, and other abnormalities of gait and mobility. A physician order, dated 4/11/24, indicated to clean buttock with normal saline, apply Santyl (wound treatment for debridement) to open area, skin prep surrounding the wound area, and cover with a bordered dressing every evening shift for wound healing. This order was discontinued on 6/4/24. A current physician order, dated 6/4/24, indicated to clean buttock with normal saline apply santyl to the open area, skin prep the surrounding wound area and cover with bordered dressing every shift for wound healing.	F 0686	F686 Treatments/Svcs to Prevent/Heal Pressure Ulcer The facility respectfully requests desk review for this citation Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Immediate actions taken for those residents identified: • Treatment was completed and documented correctly for resident #70. • The resident was assessed, orders and care plan reviewed and updated. 2) How the facility identified other residents: • Any resident residing in the facility that had a pressure area	07/29/2024

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	Review of the treatment administration record for May and June 2024 indicated wound treatments were not completed on the following dates and shifts: a. 5/5/24 - evening shift b. 5/10/24 - evening shift c. 5/12/24 - evening shift d. 5/25/24 - evening shift e. 5/27/24 - evening shift f. 6/9/24 - night shift g. 6/10/24 - day and night shift h. 6/22/24 - day and night shift The clinical record lacked indication of why the resident's right buttock treatments were not completed. A significant change Minimum Data Set (MDS), dated 4/15/24, indicated the resident was cognitively intact. He required moderate assistance from staff to roll left and right and maximal assistance for toileting and transfers. The resident exhibited occasional urinary incontinence and frequent bowel incontinence. He had one unstageable pressure injury due to coverage of wound bed by slough or eschar. It was not present on admission. Interventions included pressure injury care. A current care plan, dated 2/9/24, indicated the resident had impaired skin integrity related to an unstageable right buttock pressure injury. Interventions included the following: treatments per physician orders (2/22/24), low air loss mattress (3/14/24), and treatment as prescribed by wound care (2/15/24). A current care plan, dated 2/9/24, indicated the resident had chronic condition with risk for		had the potential to be affected. • Treatment Orders were reviewed for those residents identified to have pressure areas and care plans were updated. 3) Measures put into place/ System changes: • Orders reviewed for Treatments of pressure/skin areas. • Education provided on Medication/Treatment administration • Those residents identified to have skin areas will be reviewed during routine weekly wound rounds per wound Nurse Practioner, new orders will be immediately implemented. . • Treatment administration records will be reviewed during the morning clinical meeting and concerns reported/discussed to DON/designee. • Follow-up will occur within 24 hours for concerns regarding MAR/TAR documentation. • Education provided on Medication/Treatment administration. • Education provided on following physician orders. 4) How the corrective actions will be monitored: • The responsible party for this plan of correct will include the Director of Nursing/designee, with Executive Director oversight • Audits will be conducted weekly on 3 residents to determine accurate documentation of	

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	discomfort, complications, or decline related to a displaced intertrochanteric fracture of the left femur, subsequent encounter for closed fracture with routine healing. Interventions included enhanced barrier precautions as posted (4/30/24). A wound assessment, dated 2/22/24, indicated a new right buttock stage 2 pressure injury (partial thickness skin loss with exposed dermis) measured 3.5 centimeters (cm) length (L) by 2.5 cm width (W) by 0.1 cm depth (D). A provider progress note, dated 3/19/24, indicated the resident's right buttock stage 2 wound evolved to an unstageable pressure injury (obscured full-thickness skin and tissue loss) upon readmission from the hospital. A wound note, dated 6/13/24, indicated the right buttock unstageable pressure injury measured 1.9 cm L by 1.8 cm W by 0.1 cm D and was acquired in-house. A wound note, dated 6/25/24, indicated the right buttock unstageable pressure injury was improving with delayed wound closure. The wound measurement was 2.0 cm L by 1.5 cm W by 0.1 cm D. The skin and wound note indicated, on 5/21/24, the provider spoke with the resident and wound nurse about assessing the resident and debridement two times a week to increase healing, due to a lag in healing time. On 5/28/24 the wound was stable and debrided (dead tissue removed). On 6/13/24, the wound remained stalled with slough in place. During a wound observation on 6/27/24 at 2:38 p.m., LPN 12 and CNA 13 entered the resident's room for wound care. LPN 12 used gloved hands and removed a moderately soiled dressing, dated		treatments. • Nurse Practitioner will round weekly and review with the Director of Nursing and Unit Managers concerns that necessitate immediate action. • Additionally, residents identified to have pressure/ non-pressure related areas will have areas measured weekly to ensure assessments, treatments, current physician orders, and care plans are updated to include interventions are in place. • Results of these audits will be reviewed during stand-up meetings as well as reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 7-29-2024	

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	6/25/24, from the resident's right buttock. The nurse confirmed the dressing was dated 6/25/24. The dressing had not been changed on 6/26/24. During an interview on 6/28/24 at 3:58 p.m., LPN 18 indicated the resident's clinical record lacked indication of the ordered treatment being completed on several shifts in the treatment administrator record (TAR). It was unacceptable to not complete the treatments as ordered. There was no way to show the treatment had been administered when it was left blank. During an interview on 6/28/24 at 4:40 p.m., the DON indicated treatment/wound care orders should have been completed as ordered by the physician to promote healing of a wound. A current facility policy, dated 11/2023 and titled "Treatment/Service to Prevent/Heal Pressure Ulcers," provided by the DON on 7/1/24 at 1:45 p.m., indicated the following: "...INTENT: It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs. PROCEDURE: 1. The facility will ensure that based on the comprehensive Assessment of a resident: ... b. A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing...." 3.1-40(a)(2)			
F 0695 SS=D	483.25(i) Respiratory/Tracheostomy Care and			

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Bldg. 00	Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview the facility failed to follow physician orders related to oxygen administration for 2 of 4 residents reviewed for respiratory care. (Residents 60 and 73) Findings include: 1. During an observation on 6/24/24 at 11:23 a.m., Resident 60 was seated upright in bed with a nasal cannula in place. The oxygen concentrator was set to 4 liters per minute. On 6/24/24 at 2:17 p.m., Resident 60 was observed slumped down in her bed with her nasal cannula in place. The oxygen concentrator was set to 4 liters per minute. On 6/25/24 at 10:25 a.m., Resident 60 was observed lying in bed with her nasal cannula in place. The oxygen concentrator was set to 4 liters per minute. On 6/26/24 at 11: 11 a.m., Resident 60 was lying in bed, with her head elevated and her nasal cannula in place. The oxygen concentrator was set to 4 liters per minute. On 6/26/24 at 3:22 p.m., Resident 60 was slumped	F 0695	F695 D Respiratory /Tracheostomy Care and suctioning The facility respectfully requests paper compliance for this citation Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by both Federal and State laws. (1) Immediate action taken for those residents identified to have been affected: • Orders for Oxygen were audited and implemented for residents receiving oxygen. Residents #60 and 73 were assessed, Orders reviewed, and care plans updated to reflect residents' status for oxygen use. (2) How did the facility identify those other residents that had the potential to be affected: • The DON/ADON/designee will audit current residents to ensure	07/29/2024

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	down in her bed with her nasal cannula in place. The oxygen concentrator was set to 3.5 liters per minute. Resident 60's clinical record was reviewed on 6/26/24 at 2:15 p.m. Her diagnoses included chronic obstructive pulmonary disease (COPD), acute bronchitis, unspecified asthma, and chronic pain. Resident 60's current physician orders, dated 4/23/23, indicated continuous oxygen at 2-3 liters per minute by nasal cannula for shortness of breath. An Admission Minimum Data Set (MDS) assessment, dated 8/28/23, indicated she required oxygen. A current respiratory care plan, initiated on 8/21/23, indicated the resident is at risk for discomfort, complications, and decline related to COPD. The interventions included was to provide oxygen per physicians orders and elevate the head of the bed for comfort measures. During an interview, on 6/27/24 at 12:41 p.m., the Family Tree Unit Manager indicated Resident 60's oxygen concentrator was set to 3.5 liters, instead of between 2 and 3 liters. The nurse on shift was to ensure the residents oxygen was set to the correct liters per the physicians orders. 2. During an observation on 6/24/24 at 11:12 a.m., Resident 73 was lying in bed watching television, with his nasal cannula in place. He indicated his oxygen should be set on 2 liters per minute. The oxygen concentrator was set to 3 liters per minute. On 6/25/24 at 10:37 a.m., Resident 73 was fully		that all residents that require oxygen have current physician orders in place and their care plans reflect the resident's status. • Physician orders will be followed. (3) Measure put into place/Systemic changes: • The DON/ADON/designee will educate licensed nurses on policy and procedures for following physician orders and ensuring that the care plan reflects resident status. • Review new orders and new admissions in the morning clinical meeting, to determine those residents' requiring oxygen have current orders in place, and care plan reflects resident s status for oxygen use. • Unit managers will randomly audit oxygen liters during routine facility rounding 3 times weekly to determine physician orders are followed related to oxygen usage. (4) How the corrective actions will be monitored: • The DON/ADON/ designee will audit new orders during morning clinical meetings to ensure that new residents requiring oxygen have current orders in place and care plan reflects status for oxygen use. • The responsible party for this plan of correction will be the DON with ED oversight. • Audit reviews 3 times weekly until 100% compliance has been achieved for 6 months or which	

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	dressed, lying in his bed with his nasal cannula in place. The oxygen concentrator was set to 3 liters per minute. On 6/26/24 at 11:14 a.m., Resident 73 was lying in bed with his nasal cannula in place. The oxygen concentrator was set to 3 liters per minute. On 6/27/24 at 12:09 p.m., Resident 73 was seated in his bed with his nasal cannula in place. The oxygen concentrator was set to 3.5 liters per minute. Resident 73's clinical record was reviewed on 6/27/24 at 1:08 p.m. His diagnoses included COPD, emphysema and unspecified atrial fibrillation. Resident 73's current physicians orders, dated 4/5/22, indicated the resident may use oxygen at 2 liters per minute by nasal cannula 24/7. A quarterly MDS assessment, dated 5/15/24, indicated the resident required oxygen. A current respiratory care plan, initiated 6/8/23, indicated the resident was at risk for discomfort, complications, and decline related to COPD and emphysema. The interventions included were to provide oxygen per physicians orders and elevate the head of the bed for comfort measures. During an interview on 6/27/24 at 12:18 p.m., LPN 32 indicated the nurse on staff was responsible for checking the oxygen concentrator and ensure they were set as ordered by the physician. During an interview on 7/1/24 at 2:58 p.m., the DON indicated the expectation for the nursing staff is to ensure the physician orders were being followed.		compliance has been met at 100% for 3 months at which time the QA committee may decide to adjust the plan of care. • All findings will be brought to the Quality Assurance Performance Improvement Committee monthly for ongoing compliance review. (5) Date of Correction: 7-29-2024	

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	Review of a current facility policy, dated 12/1/23 and titled " Physician Services and Orders," provided by Corporate Nurse Consultant 7 on 7/1/24 at 3:07 p.m., indicated the following: "...11. All physician orders will be followed as prescribed and if not followed, the reason shall be recorded in the resident's medical record during the shift...." 3.1-47(a)(6)			
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all			

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	controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to ensure shift to shift narcotic reconciliation was completed for 6 of 6 carts reviewed for medication storage of 11 total medication and treatment carts. (Rehab cart, Intermediate back cart, 400 hall cart, 500 hall cart, 200 hall cart and 300 hall cart) Findings include: 1. During a medication storage observation of the 400 hall cart, accompanied by LPN 33, on 6/26/24 at 9:23 a.m., the "Controlled Substances Check Form" record was reviewed and the following dates lacked shift to shift reconciliation of controlled substances: In June 2024- 6/1, 6/2, 6/3, 6/4, 6/5, 6/6, 6/7, and 6/8 on all three shifts, 6/10 on evening and night shifts, 6/11 on day and evening shifts, 6/12 from 6:00 p.m.- 10:00 p.m. and night shift, 6/13 on day shift and 2:00 p.m. - 6:00 p.m., and night shift 6/17 on day shift and 2:00 p.m.- 6:00 p.m., 6/18 on evening and night shift, 6/19 on day shift, 6/21 on day shift and night shift, 6/22 on all three shifts, 6/24 on night shift, 6/25 on all three shifts.	F 0755	F 755D Pharmacy Srvcs/Procedures/Pharmacist/Records The facility respectively requests a desk review for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Controlled drugs were reconciled in all facility med carts. 2)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: • No resident was identified to have been affected. 3)What measures will be put into place or what systemic changes	07/29/2024

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	2. During a medication storage observation of the 500 hall cart, accompanied by LPN 34, on 6/26/24 at 9:23 a.m., the "Controlled Substances Check Form" record was reviewed and the following dates lacked shift to shift reconciliation of controlled substances: In June 2024- 6/2 on day shift, 6:00 p.m. - 10:00 p.m., and night shift, 6/4 from 6:00 p.m. - 10:00 p.m., and night shift 6/5 on evening shift and night shift, 6/6 on night shift, 6/8 on evening and night shift, 6/9 on all three shifts, 6/10 on all three shifts, 6/11 on night shift, 6/12 on all three shifts, 6/13 on all three shifts, 6/14 on day and evening shifts, 6/16 on all three shifts, 6/18 on all three shifts, 6/20 on day and night shifts, 6/23 on all three shifts, 6/24 on all three shifts, 6/25 on all three shifts. 3. During a medication storage observation of the Rehab hall cart, accompanied by LPN 9, on 6/26/24 at 9:47 a.m., the "Controlled Substances Check Form" record was reviewed and the following dates lacked shift to shift reconciliation of controlled substances: In June 2024- 6/6 on night shift, 6/19 on day shift and 2:00 p.m. - 6:00 p.m.,		will be made to ensure that the same deficient practice does not recur: • Facility will implement Clean Friday Cart Audits every Friday to determine accurate reconciliations for shift-to-shift narcotic counts. • Nursing staff educated on shift-to-shift narcotic reconciliations. • Identified areas of concern will result in re-education and or disciplinary action 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: • The responsible party for this plan of correction is the Director of Nursing with Executive Director oversight • Audits will be conducted by the Unit Managers using “Clean Friday” Audit tool to determine accurate reconciliation of shift-to-shift narcotic counts. Audits will continue for 6 months or until 100% compliance has been met for 3 consecutive months. • The QA Committee will review monthly during QAPI meeting to identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of Correction 7-29-2024	

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	6/23 on night shift, 4. During a medication storage observation of the 200 hall cart, accompanied by QMA 20, on 6/26/24 at 10:03 a.m., the "Controlled Substances Check Form" record was reviewed and the following dates lacked shift to shift reconciliation of controlled substances: In June 2024- 6/2 on all three shifts, 6/3 on day shifts and 2:00 p.m. - 6:00 p.m., 6/4 from 6:00 p.m. - 10:00 p.m., 6/5 on evening shift, 6/6 on evening and night shifts, 6/8 on day shift and from 2:00 p.m. - 6:00 p.m., 6/9 from 6:00 p.m.- 10:00 p.m. and night shift, 6/10 on all three shifts, 6/12 on evening and night shifts, 6/13 on evening and night shifts, 6/14 from 11:00 p.m. - 6:00 a.m., 6/15 on night shift, 6/18 on night shift, 6/19 on night shift, 6/20 on night shift, 6/24 on evening and night shifts, 6/25 on evening shift. 5. During a medication storage observation of the Intermediate back hall cart, accompanied by LPN 10, on 6/26/24 at 11;10 a.m., the "Controlled Substances Check Form" record was reviewed and the following dates lacked shift to shift reconciliation of controlled substances: In June 2024- 6/2 on day shift and 2:00 p.m. - 6:00 p.m., 6/7 on evening shift,			

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	6/9 from 2:00 p.m. - 6:00 p.m., 6/10 on day shift and 2:00 p.m. - 6:00 p.m., 6/12 from 2:00 p.m. - 6:00 p.m., 6/14 on day shift, 6/15 on day shift, 6/17 on night shift, 6/18 from 6:00 p.m. - 10:00 p.m. and night shift, 6/19 from 12:00 a.m. - 6:00 a.m., 6/21 from 6:00 p.m. - 10:00 p.m. and night shift, 6/22 on night shift, 6/23 from 6:00 p.m. - 10:00 p.m., 6/25 on evening and night shift, 6. During a medication storage observation of the 300 hall cart, accompanied by LPN 35, on 6/26/24 at 11:24 a.m., the "Controlled Substances Check Form" record was reviewed and the following dates lacked shift to shift reconciliation of controlled substances: In June 2024- 6/1 on day and evening shifts, 6/2 on night shift, 6/4 on evening shift, 6/5 on evening shift, 6/6 from 2:00 p.m. - 6:00 p.m., 6/8 on day shift, 6/13 from 2:00 p.m. - 6:00 p.m., 6/14 on night shift, 6/15 from 12:00 p.m. - 2:00 p.m., 6/20 from 2:00 p.m. - 6:00 p.m., 6/23 on night shift, 6/25 from 2:00 p.m. - 6:00 p.m., During an interview, on 6/26/24 at 10:19 a.m., the Family Tree Unit Manager indicated the expectation was for the nursing staff to sign the "Controlled Substances Check Form" at the start and end of each shift. She was not sure why this			

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	task was not being completed as expected. During an interview, on 6/26/24 at 10:13 a.m., the DON indicated all nurses were to sign the narcotic counts sheets for persons taking over the cart and the person leaving the cart. A lack of signature and incomplete counts was a risk for drug diversion. A current, undated, facility policy titled, "Narcotic Nurse to Nurse Reconciliation," provided by the DON on 7/1/24 at 3:45 p.m., indicated the following: "... When keys to secured storage area occur between 2 applicable licensed staff there will be a count that is completed to validate the items are accurate....Each reconciliation will require: 1. Two signatures (on coming and off going)..." 3.1- 25(b)(3)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

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	§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure insulin (a medication to treat diabetes mellitus) vials were dated when opened and disposed of when expired for 2 of 6 carts reviewed for medication storage. (Rehab hall cart and 400 hall cart) Findings include: During a medication storage observation of the 400 hall cart, accompanied by LPN 33 on 6/26/24 at 9:23 a.m., the following was observed: One open vial of Lispro (rapid-acting) insulin, dated 5/15/24; the vial was approximately half full. One open vial of Glargine (long-acting) insulin, dated 5/21/24; the vial was approximately half full. One open vial of Lispro (rapid-acting) insulin, dated 5/28/24; the vial was approximately half full. During an interview at the time of the observation, LPN 33 indicated she thought insulin was good for 30 days, but if a nurse was unsure how long medication was good for, she should ask the unit manager or another staff member. The insulins dated 5/15/24, 5/21/24, and 5/28/24 were expired and should no longer be used. There were 3 residents on the 400 hall that utilized insulin medication.	F 0761	F 761 D Label/Store Drugs and Biologicals This facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.) Corrective actions accomplished for those residents found to be affected by the alleged practice: • No resident identified to have been affected. Identified insulin was destroyed • Audit of facility medication carts was completed for dated and expired medications. Any identified medications were	07/29/2024

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	During a medication storage observation of the Rehab hall cart, accompanied by LPN 9, on 6/26/24 at 9:47 a.m., the following was observed: Two opened undated vials of Lispro insulin. One opened undated vial of Lantus (long-acting) insulin. During an interview at the time of the observation, LPN 9 indicated she was unaware of when the vials were opened and she had not given insulin to the residents on her shift. Two residents on the Rehab hall utilized insulin medication. During an interview on 6/26/24 at 11:10 a.m., LPN 10 indicated opened insulin vials were good for 30 days. During an interview on 6/27/24 at 11:54 a.m., LPN 32 indicated insulin was good for 30 days. The narcotics book, stored on all medication carts, contained a "Product Expiration Dates" page with information with about medications and when to dispose of them. The expired insulin on the 400 hall cart should be disposed of. During an interview on 6/26/24 at 9:51 a.m., the Family Tree Unit Manager indicated insulin was good for 28 days and should be dated when opened. A current facility document, revised 5/23 and titled "Product Expiration Dates," provided by the DON on 6/27/24 at 11:41 a.m., indicated the following: "...Room temperature expiration date for insulin vials is 28 days..." A current facility policy, revised 11/22 and titled "Labeling and Storage of Medication/Biologicals," provided by the DON on		destroyed. 2.) Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: • Any current resident had the potential to be affected, however no resident was identified. • An audit was conducted to determine no expired medications were identified on medication carts and medication rooms. 3.) Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: • DON/ designee educated the Licensed Nurses / QMAs on the following policy: Labeling and Storage of Medications. • Audits per Director of Nursing/Designee will be conducted weekly utilizing Clean Friday Audit tool to determine medications are stored and labeled correctly. • Any issue identified will result in immediate re-education and or disciplinary action 4.) How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: • Responsible party for this plan of correction is the Director of Nursing/designee with Executive Director oversight.	

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	6/27/24 at 11:41 a.m., indicated the following: "... Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened...." 3.1-25(j) 3.1-25(k)		• Audit results will be reviewed weekly via the Director of Nursing for compliance and additionally thru the monthly QAPI meetings for a minimum of 6 months or until compliance is met at 100% for consecutive three months, at which time QA committee may determine/recommend revision of plan of correction. . 5.) Date of compliance: 7-29-2024	
F 0867 SS=E Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and			

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	including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement			

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	activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and			

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	assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. Based on record review and interview, the facility failed to develop and implement approaches to correct identified deficient practices and audits to measure success of Performance Improvement Plans (PIP) as part of the Quality Assurance and Performance Improvement (QAPI) program. Findings include: During an interview, on 6/26/24 at 10:14 a.m., the DON indicated she had started Performance Improvement Plan (PIP) for an identified concern at the facility, such the failure of nurses to sign in and out to acknowledge reconciliation of the narcotic medication at the change of shift. She indicated the completion date for her PIP was 9/13/24. A current facility PIP guide, provided by the DON on 6/26/24 at 10:14 a.m., indicated the start date as 6/13/24 for nurses not signing in and out on the record of accepting narcotic responsibilities. The plan or tasks to be completed included a review of sign in/sign out sheets, a staff in-service, and	F 0867	F867 QAPI/QAA Improvement Activities The facility respectfully requests a desk review for this citation Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1.) Immediate actions taken for those residents identified: • The facility (QA) Committee meeting was held to review the purpose and function of the Quality Assurance Performance Improvement Committee and review on-going compliance	07/29/2024

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	"Clean Fridays" audits were to be initiated. The staff in-service was held on 6/13/24. The facility nursing staff was verbally re-educated on 6/26/24. During an interview, on 7/2/24 at 3:00 p.m., the DON indicated she did not have any audit tools, additional documentation, or evidence to provide to support the implementation of approaches listed on the PIP guidance tool. The Family Tree Unit Manager was doing reviews of the medication cart narcotics binders on Fridays, but the DON had not created the "Clean Fridays" tool as of yet. She indicated on the review dates listed, she would analyze the audit tools and complete the sections measuring the outcome of the action plan. Review of a current facility policy, titled, "Quality Assurance and Performance Improvement", dated 11/23, and provided by the Administrator following the Entrance Conference on 6/24/24, indicated the following: "... Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating system identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities..." Cross reference F755. Cross reference F761. 3.1-52(b)(2)		issues. • Identified members of QA committee will attend QAPI meetings on an ongoing basis and will assign additional team members as appropriate. Information was provided to the medical Director regarding the current plan of correction 2.) How the facility identified other residents: • All residents have the potential to be affected by this practice. 3.) Measures put into place/ System changes: • The QAPI committee will meet at a minimum of monthly to identify issues related to quality assessment and assurance activities (or as needed) and will develop and implement appropriate plans of action for identified facility concerns. 4.) How the corrective actions will be monitored: • The Executive Director and the Director of Nursing along with the QAPI Committee will review monthly, including the medical director, will review at least quarterly compiled QAPI report information and review trends and corrective actions taken and the dates of completion. • The QAPI committee will validate the facility's progress in correcting the deficient practices or identify concerns. • The Executive Director will be responsible for ensuring QAPI	

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			committee concerns are addressed through further education, training or other interventions • Audits Provided on identified concerns/ issues will be reviewed monthly during Quality Assurance. • Audits will continue monthly for 6 months and or until 100% compliance is achieved for 3 consecutive months at which time the committee may make recommendations to revise the plan. 5.) Date of Compliance 7-29-2024	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers,			

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	visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the			

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	facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to follow infection prevention and control procedures during wound care related to Enhanced Barrier Precautions (EBPs) for 2 of 5 resident reviewed for skin impairments. (Residents 70 and 83) Findings include: During an observation on 6/24/24 at 11:02 a.m., Resident 70's door was closed with an Enhanced Barrier Precaution sign noted on the left side of the door. A personal protective equipment (PPE) canister was to the left of the door just outside the resident door. The sign was readily visible and indicated to use hand hygiene, a gown, and gloves for all high contact resident care to include wound care. During a wound observation and interview on 6/27/24 at 2:38 p.m., LPN 12 and CNA 13 entered Resident 70's Enhanced Barrier Precaution room with the sign visible to the left side of the door along with the personal protective equipment canister. They both performed hand washing, donned gloves, then LPN 12 set everything up for wound care. LPN 12 used gloved hands and removed the moderately soiled dressing from the resident's right buttock. CNA 13 was there to	F 0880	F 880 D Infection Prevention and Control The facility respectfully requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: • Residents #70 and #83 were assessed, orders reviewed, and care plans updated accordingly. • Education provided to facility staff regarding enhanced barrier precautions.	07/29/2024

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	assist with the wound care. Neither LPN 12 nor CNA 13 donned a gown. Throughout wound care, both LPN 12 and CNA 13 leaned up against the resident's mattress with their unprotected clothing. The wound bed on the right buttocks was covered with slough and consistent with the last wound assessment measurements and description. Resident 70's clinical record was reviewed on 6/26/24 at 4:20 p.m. A current physician order, dated 4/25/24, included the following: Enhanced Barrier Precaution Isolation for high contact resident activity. Gown and glove use was required for dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy), or wound care every shift. During an observation on 6/24/24 at 11:59 a.m., Resident 83's room had an Enhanced Barrier Precaution sign noted to the left of her door. Upon entry to the room, the Personal Protective Equipment (PPE) canister was located behind the door in a canister. Resident 83's clinical record was reviewed on 6/27/24 at 10:22 a.m. A current physician's order, dated 4/25/24, included the following: Enhanced Barrier Precaution Isolation for high contact resident activity. Gown and glove use was required for dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy), or wound care every shift. During a wound observation on 6/27/24 at 3:39 p.m., LPN 12 approached Resident 83's room with		• No resident was identified to have been affected. 2) How the facility identified other residents: • Any resident requiring EBP had the potential to be affected, however no resident was identified. 3) Measures put into place/ System changes: • In servicing was provided to facility staff on Enhanced Barrier Precautions. 4) How the corrective actions will be monitored: • The Director of Nursing /Infection Preventionist/Designee will observe facility staff weekly utilizing proper process for Enhanced Barrier Precautions. • Identified areas of concern will be addressed immediately through 1-1 education and or disciplinary action. • Staff will be educated upon hire and at least annually on infection control practices. • Results of above reviews will be reported to QAPI monthly for 6 months or until compliance is met at 100% for 3 months when the QA Committee will review for trending or patterns and make recommendations as required to the plan of correction. 5) Date of compliance: 7-29-2024	

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	an Enhanced Barrier Precaution sign hung on the left side of the resident's door. The sign indicated high contact care such as wound care required hand hygiene, a gown, and gloves. Upon entry to the resident's room, LPN 12 washed her hands. She donned gloves for wound care but did not wear a gown for the wound care. Upon removal of the dressing, the wound to the left lateral foot was open and slightly smaller than the tip of an eraser with a discernable depth. A small amount of serous drainage was noted on the removed dressing. During an interview on 6/27/24 at 4:00 p.m., LPN 12 indicated Residents 70 and 83's rooms had EBP signage on the doors, readily visible prior to entry to the rooms. She had just performed wound care with both of these residents without the use of a gown in either room. She was uncertain if both of the residents were listed for use of EBPs during wound care or if the sign was posted for their roommates. During an interview on 6/27/24 at 4:10 p.m., LPN 10 indicated any high contact care for residents with open wounds required the use of EBPs. Required personal protective equipment (PPE) included proper hand hygiene, gown, and glove use. Wound care was considered high contact care. During an interview on 6/27/24 at 4:14 p.m., CNA 13 indicated she was uncertain what PPE should have been worn for EBPs and when EBPs should have been utilized or implemented. She had just assisted with wound care in Resident 70's room with an EBP sign on the door. She had not worn a gown during the wound care. She then read the EBP sign on the door and indicated she should have worn a gown in addition to her gloves			

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BEAUMONT REHABILITATION AND HEALTHCARE CENTER	1345 N MADISON AVE ANDERSON, IN 46011

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	during the wound care for Resident 70. During an interview on 6/27/24 at 4:19 p.m., LPN 12 indicated both Resident 70 and Resident 83 had orders for EBPs. She had not worn a gown during wound care for Resident 70 and Resident 83 on this date. EBPs required a gown and gloves use for high contact care such as wound care. During an interview on 7/1/24 at 2:50 p.m., the DON indicated EBPs should have been followed by all staff during wound care. The facility followed physician's orders as it was a nursing standard of practice. A current undated facility policy, titled "Enhanced Barrier Precautions," provided by Corporate Nurse Consultant 7 on 7/1/24 at 8:45 a.m., indicated the following: "Policy Statement... Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms... Policy Interpretation and Implementation 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a) Gloves and gown are applied prior to performing the high contact resident care activity... 3) Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: ... h) wound care...." 3.1-18(b)(2)			