STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155815	A. BUILDING 00 B. WING	08/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00413214. This visit included a State Residential Licensure Survey. Complaint IN00413214 - No deficiencies related to the allegations are cited. Survey dates: August 16, 17, 18, 21, and 22, 2023 Facility number: 013019 Provider number: 155815 AIM number: 201251520 Census Bed Type: SNF/NF: 24 SNF: 13 Residential: 21 Total: 58 Census Payor Type: Medicare: 8 Medicaid: 24 Other: 26 Total: 37 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 29, 2023	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Recertification and State Licensure Survey conducted on August 22, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of September 22, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined			

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

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	that this practice is clinically appropriate. Based on observation, interview and record review, the facility failed to have the interdisciplinary team determine and document self administration of medications was clinically appropriate for 1 of 5 residents observed during medication administrations. (Resident 190) Findings include: The clinical record for Resident 190 was reviewed on 8/22/23 at 9:00 a.m. The diagnosis for Resident 190 included, but was not limited to, stroke. A physician order dated 8/20/23 indicated Resident 190 was able to receive 2 tabs of 500 milligrams of Tums three times a day as needed. During a medication administration with License Practical Nurse (LPN) 11 on 8/22/23 at 8:35 a.m., an observation was made of LPN 11 preparing medication for Resident 190. After, LPN 11 entered the resident's room and administered the pill medications he had prepared to the resident. During that time, an additional medication cup was observed at the resident's bedside with a green chewable tablet. The resident indicated to LPN 11 she needed something for upset stomach. LPN 11 left the room and returned to the medication cart. LPN 11 was observed pulling 2 tablets of 500 milligrams of Tums. After, he returned back to the resident's room with the cup of chewable tablets. The resident at that time had indicated to LPN 11 to leave the cup of chewable tablets next to the other cup at the bedside that had contained the green chewable tablet. LPN 11 asked the resident when did she get the chewable tablet. She indicate the night before. LPN 11 was observed removing the additional cup that contained the green tablet after education was	F 0554	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? ¿ Resident 190 is discharged 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. ¿ Residents that self administer medications have the potential to be affected by the alleged deficient practice. DHS or designee will educate licensed nurses on the Self Administration of Medications policy. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? • As a measure of ongoing compliance the DHS or designee will audit residents that self administer medications to ensure self medication administration assessment is complete. DHS or designee will audit 5 residents weekly times a week times 4 weeks, every 2 weeks times 2 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED	09/22/2023

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	provided to the resident medications were not suppose to be left at the bedside. An interview was conducted with LPN 11 on 8/22/23 at 8:45 a.m. LPN 11 indicated Resident 190 was confused, and she should not be left unattended with medications at the bedside. After reviewing the Medication Administration Record (MAR), LPN 11 indicated he was unsure who and when the Tums chewable tablet was left at the bedside. The MAR was not signed off Tums chewable tablets were administered. Resident 190's clinical record did not include an assessment was conducted to indicate the resident was able to self medicate safely. A "Self-administration of Medications" policy was provided by Nurse Consultant 2 on 8/22/23 at 8:30 a.m. It indicated "...Purpose: To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is a part of their plan of care. Procedures 1. Residents requesting to self-medicate or has self-medication as a part of care shall be assessed using he observation Trilogy-Self Administration of Medication within the electronic health record. Results of he assessment will be presented to the physician for evaluation and an order for self-medication. a. The order should include the type of the medication(s) the resident is able to self-medicate. ie.: all oral meds, oral meds with the exception of...,nebulizer treatment only, all medications including injection, oral, inhalers, drops, etc...A Self-Medication plan of care will be initiated and updated as indicated..." 3.1-11		4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. 5. Date of completion: 9/22/2023	

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F 0559 SS=D Bldg. 00	483.10(e)(4)-(6) Choose/Be Notified of Room/Roommate Change §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to inform a resident of a room change, prior to it being initiating, for 1 of 1 resident reviewed for abuse (Resident 10). Findings include: The clinical record for Resident 10 was reviewed on 8/16/23 at 2:44 p.m. The Resident's diagnosis included, but were not limited to, anxiety and dementia. A care plan, initiated on 8/14/22, indicated that Resident 10 had impaired cognition, which fluctuates, and impaired short-term memory, with risk for confusion, disorientation, altered mood, and impaired or reduced safety awareness related to dementia. The goal was that she would remain safe and not injure herself secondary to impaired decision making. The interventions, initiated 8/14/22, included to re-direct her when agitated	F 0559	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? • Resident 20 did not move rooms 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. • All residents have the potential to be affected by the alleged deficient practice. ED or designee to educate the IDT Team on the Notification of Room and Roommate Change Policy. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	09/22/2023

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	behaviors are present or a potential for injury is evident, pay attention to basic needs and provide ADL (Activities of Daily Living) care as required, provide cues and supervision for decision making, in new situations, provide support and reassurance. An Admission MDS (Minimum Data Set) Assessment, completed 8/19/22, indicated she felt it was very important to her to take care of her own personal belongings. A Quarterly MDS Assessment, completed 2/17/23, indicated she had moderately impaired cognition. A Quarterly MDS Assessment, completed 5/19/23, indicated her cognition was intact. A Room/Roommate Notification Observation, dated 6/28/23, indicated that Resident 10 was to have a room change on 6/30/23. The 48 hour notice of relocation had not been waived. She was to move to room 402. The reason for the change was for increased staff attention. The observation form did not include that the resident or the resident representative had been notified. A Nursing Progress Note, dated 6/30/23 at 9:41 a.m., indicated Resident 10 had expressed to multiple staff members that she did not want to transfer rooms and no longer wanted to stay in the facility. Resident 10 had spoken with social services and was told that her belongings would be returned to her current room. Resident 10's family had been contacted to attempt to assist with calming her, but Resident 10 refused to speak to them and continued to yell out for someone to call the police and get her out of the facility. A progress note, dated 6/30/23 at 1:01 p.m.,		• As a measure of ongoing compliance SSD or designee will audit residents that move rooms to ensure the room change notification is documented. SSD or designee will audit 5 residents weekly times 4 weeks, every 2 weeks times 2 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. 5. Date of completion: 9/22/23	

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	indicated Resident 10 had stopped yelling and was resting peacefully in a chair. During an interview on 8/16/23 at 2:44 p.m., Resident 10 indicated that around a month ago, she had been returning from eating breakfast and saw the facility staff taking her things from her room. Resident 10 had asked the staff what they were doing with her things and had been told they were moving them. She had not been told she was moving and as far as she was concerned, they were trying to take her belongings without her permission. Resident 10 said she started yelling and asked for someone to call the police. The staff finally brought her stuff back to her room. During an interview on 8/21/23 at 2:47 p.m. the SSD (Social Services Director) indicated she had attempted to call Resident 10's family member on 6/28/23 to inform her about the room move and left a message. The SSD had brought the room move up to Resident 10 on 6/29/23. The SSD did not consider the Resident 10's family member as informed because she had not directly spoken with her and Resident 10 was not supposed to be moved on 6/30/23. The SSD had intervened and calmed Resident 10 down. She did not move that day. On 8/22/23 at 10:00 a.m., Nurse Consultant 2 provided the current Notification for Room and Roommate Change policy which read "...The Residents will be notified in writing of a change in their room or roommate, including the reason for the change...Notification to a resident who is relocating shall be provided in advance to any change..." 3.1-3(v)(2)			

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F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessments completed regarding Dental concerns for 1 of 1 resident reviewed for dental, Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident reviewed for MDS Accuracy, assistance with eating for 1 of 2 residents reviewed for Activities of Daily Living and Discharge MDS accuracy for 1 of 1 resident reviewed for discharge (Resident 2, 9, 18 and 38) Findings include: 1. The clinical record for Resident 2 was reviewed on 8/16/23 at 1:30 p.m. The Resident's diagnosis included, but were not limited to, dementia and dysphasia (difficulty swallowing). She was admitted from an acute care hospital to the facility on 7/7/23. A nursing progress note, dated 7/9/23 at 6:17 p.m., indicated an assessment of Resident 2 revealed pain to mouth and throat and a large, abscess-like area along the gum line on the bottom left side of her mouth. A physician's progress note, dated 7/10/23 at 11:29 a.m., indicated Resident 2 had a possible dental abscess. Her right jaw showed as to be painful and mildly swollen. An Admission MDS (Minimum Data Set) Assessment, completed 7/13/23, indicated	F 0641	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? • Residents 2, 9, 18, and 38 were affected. Residents are without adverse effects. 7/13/23 MDS for Resident 2 modified to reflect accurate oral/dental status. 6/22/23 MDS for Resident 9 modified to reflect accurate eating support provided. 7/7/23 MDS for Resident 18 modified to reflect accurate PASRR Level II coding. 6/26/23 MDS for Resident 38 modified to reflect accurate coding of discharge location status. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. • All residents have the potential to be affected. MDS Coordinator educated on accurately assessing and coding of Section L: Oral/Dental Status, Section G: Eating Support Provided, Section A: Preadmission Screening and Resident Review (PASRR), and Section A: Discharge Status per RAI guidelines. 3: What measures will be put into	09/22/2023

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	Resident 2 had no dental concerns present. 2. The clinical record for Resident 9 was reviewed on 8/16/23 at 2:00 p.m. The diagnosis for Resident 9 included, but was not limited to, kidney disease. The annual MDS assessment dated 6/22/23 indicated Resident 9 was needing limited assistance with 2 staff persons for eating. An observation was made of Resident 9 on 8/18/23 at 11:42 a.m. The resident was sitting in the dining room eating pureed lunch meal. The resident was eating with no assistance by staff. 3. The clinical record for Resident 18 was reviewed on 8/17/23 at 8:30 a.m. The diagnosis for Resident 18 included, but was not limited to, bipolar disorder. A PASRR Level II conducted on 8/29/22 indicated the resident did not require specialized services. "Important information...Since this evaluation has determined that you have a PASRR condition., If you admit to a Medicaid-certified nursing facility, or if you are currently in a Medicaid-certified nursing facility, the facility will need to document your PASRR condition in the Minimum Data Set (MDS) assessment record. The facility should mark yes to question A1500 on the MDS, 'Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?' Also, your specific PASRR condition(s) should be checked in question A1510 , 'Level II Preadmission Screening and Resident Review (PASRR) Conditions." The Significant change MDS assessment dated 7/7/23 indicated the resident had not been evaluated by PASRR level II and determined the		place or what systemic changes will be made to ensure that the deficient practice does not recur? • As a measure of ongoing compliance, the Assessment Support Nurse or designee will conduct an audit of five residents (as available) for correct MDS coding of Section L: Oral/Dental Status, Section G: Eating Support Provided, Section A: Preadmission Screening and Resident Review (PASRR), and Section A: Discharge Status weekly x4 weeks, then twice per month x2 months, then monthly x3 months. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met.	

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	resident had a mental illness. 4. The clinical record for Resident 38 was reviewed on 8/21/23 at 10:27 a.m. Her diagnoses included, but were not limited to, chronic obstructive pulmonary disease and depression. She was admitted to the facility on 4/12/23 and discharged to an assisted living facility on 6/26/23 at 12:35 p.m. The 6/26/23 Discharge MDS assessment indicated she discharged to another nursing home or swing bed. During an interview on 8/21/23 at 1:59 p.m., the MDSC (Minimum Data Set Coordinator) indicated that oral pain and broken teeth should have been captured on Resident 2's Admission MDS Assessment. Resident 9's PASRR level II should have been marked as yes, the resident had been evaluated on the Significant change MDS assessment on 7/7/23. The MDSC had completed the Discharge MDS Assessment for Resident 38. There had been a transcription error, and it should have indicated that Resident 38 had discharge to the community, not another nursing home. The facility used the RAI (Resident Assessment Instrument) as the facilities policy for completing MDS Assessments. An interview was conducted with the MDS Coordinator on 8/21/23 at 3:25 p.m. He indicated Resident 9's annual MDS assessment dated 6/22/23 requiring 2 staff persons for eating was entered incorrectly.		5. Date of completion: 9/22/23	
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary			

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	that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.			
	Based on interview and record review, the facility failed to prepare a discharge summary that included a recapitulation of the resident's stay, a final summary of the resident's status, a reconciliation of all pre and post discharge medications, and a discharge plan of care for 1 of 1 resident reviewed for discharge. (Resident 38) Findings include: The clinical record for Resident 38 was reviewed on 8/21/23 at 10:27 a.m. Her diagnoses included,	F 0661	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? • Resident 38 is discharged. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. ¿ All residents that are discharged	09/22/2023

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	but were not limited to, chronic obstructive pulmonary disease and depression. She was admitted to the facility on 4/12/23 and discharged to an assisted living facility on 6/26/23 at 12:35 p.m. The 5/22/23 Resident First Meeting note indicated Resident 38's discharge plan was unknown due to her physical decline. The 6/22/23, 1:30 p.m. social services note, written by the SSD (Social Services Director) and recorded as a late entry on 6/28/23 at 9:20 a.m., read, "On this date writer received a call from [name of assisted living facility's] admission director, requesting clinical information on resident. Call was made to POA [power of attorney] in efforts to verify that request was made on her behalf. Per POA interest had been voiced in that facility during a recent tour herself and resident had. Writer explained the discharge/transfer process and expressed to POA that she would assist if needed once decision was made. POA voiced understanding." The 6/26/23 physician's order read, "RESIDENT MAY ADMIT TO ASSISTED LIVING." The 6/26/23, 9:20 a.m., social services note, written by the SSD, recorded as a late entry on 6/28/23 at 9:27 a.m., and edited by the SSD on 8/21/23 at 9:27 a.m., read, "Writer received email from [name of assisted living facility] requesting MD signed documents for admission. POA then came into facility stating she was taking resident out and moving her to another facility. Discharge process was not able to be followed as POA did not alert writer or IDT of planned discharge. Writer was successful in getting all orders and sent to new facility. No issues or concerns voiced related to		have the potential to be affected by the alleged deficient practice. DHS or designee to educate nursing staff on the process of completing the discharge summary. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ¿ DHS or the designee will be responsible for auditing resident discharges to ensure a discharge summary is completed, when appropriate. An audit of 5 residents will be conducted 2 times a week times 4 weeks, 1 time a week times 4 weeks, every 2 weeks times 3 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted.	

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	155815	A. BUILDING 00 B. WING	08/22/2023

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	stay. When POA was asked why transfer was immediate without planning, POA voiced resident had received her Medicaid waiver and did not want to risk loosing open bed at new facility." There was no discharge summary in Resident 38's clinical record. An interview was conducted with the SSD on 8/21/23 at 11:20 a.m. She indicated she was not present in the facility when Resident 38 discharged. When she returned to work on 6/28/23 after being off, Resident 38 was already discharged. Resident 38's family took her out and the SSD didn't know she was leaving. Originally, Resident 38 planned to discharge home, then was going to remain in the facility long term, then went through the Medicaid waiver process and discharged the same day. The SSD spoke with Resident 38's daughter, Family Member 4, on 6/22/23, but they hadn't yet made a decision to discharge to the assisted living facility referenced in the SSD's 6/22/23 note. To her, it was an unplanned discharge. An interview was conducted with NC (Nurse Consultant) 3 on 8/21/23 at 1:45 p.m. She indicated they only do discharge summaries for planned discharges, and Resident 38's was not planned. An interview was conducted with the SSD, NC 2, NC 3, and CSS (Customer Service Specialist) 11 on 8/21/23 at 2:43 p.m. The SSD indicated she spoke with the Admissions Director of the assisted living facility on 6/22/23 and sent the requested information, but her understanding was still that Resident 38's plan was to remain in their facility long term. CCS 11 indicated he was contacted by the business office manager the morning of 6/26/23 about Resident 38 discharging from the		The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. 5. Date of completion: 9/22/23	

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	facility that afternoon. Family Member 4 came into the facility later that day and said they were going to take Resident 38 and asked for a medication list. CCS 11 pulled continuing care documentation from the computer and handed it to her, but did not document this in the clinical record. NC 3 indicated there was approximately one and a half hours from the time they knew Resident 38 was leaving the facility until she actually left the facility. NC 2 indicated there was no time to complete a discharge summary. A telephone interview was conducted with Family Member 4 on 8/21/23 at 11:52 a.m. She indicated Resident 38 discharged from the facility to the assisted living facility on 6/26/23. Family Member 4 drove her there. She wanted to discharge on 6/23/23, but the assisted living facility couldn't take her until 6/26/23. The facility knew Resident 38 was moving to the assisted living facility ahead of time. She was unaware if any discharge paperwork was sent to the assisted living facility, but they gave her an invoice when she left the facility, so "they definitely knew she was leaving." The Guidelines for Transfer and Discharge policy was provided by NC 3 on 8/21/23 at 2:20 p.m. It read, "Discharge Documentation a. For anticipated discharges, a Discharge Planning observation is initiated by social services in the resident's medical record. This should include arrangements for post discharge equipment, services, psychosocial approaches for the caregiver, etc. Each service providing care after discharge should have name of agency and contact listed. b. Nursing will complete a Discharge Instructions observation at the time of discharge. A copy will be printed the resident and/or representative should sign the form and			

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	scanned into the medical record. 3.1-36(a)(1) 3.1-36(a)(2) 3.1-36(a)(3) 3.1-36(b)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to provide showers for 1 of 2 residents reviewed for Activities of Daily Living. (Resident 140) Findings include: The clinical record for Resident 140 was reviewed on 8/16/23 at 2:00 p.m. The diagnosis for Resident 140 included, but was not limited to, stroke. The resident was admitted on 8/9/23. A nursing progress note dated 8/9/23 indicated Resident was alert and oriented. A life enrichment assessment dated 8/11/23 indicated it was very important to the resident to choose bathing type. Resident 140 chose to receive showers. An observation was made of Resident 140 on 8/16/23 at 1:25 p.m. The resident's hair was observed to be greasy with white flakes in her hair. An interview was conducted with Resident 140 on	F 0677	1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident 140 received a shower. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. ¿ All residents have the potential to be affected by the alleged deficient practice. DHS or designee to educate nursing staff on the Guidelines for Bathing Preference 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ¿ DHS or the designee will be responsible for auditing to ensure residents receive bathing per their preference. An audit of 5 residents	09/22/2023

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	8/16/23 at 1:31 p.m. She indicated she had not received a shower since she was admitted to the facility. She would "love" to have a shower. The staff have washed her up, but she had not received a shower. An interview was conducted with License Practical Nurse (LPN) 22 on 8/17/23 at 10:30 a.m. The staff do use shower sheets and shower day schedule was in the 24 hour binder. The 24 hour binder was provided by LPN 22 on 8/17/23 at 10:35 a.m. It indicated Resident 140 was to receive showers on the evenings of Wednesdays and Fridays. The binder did not include shower sheets indicating showers had been provided to Resident 140 on 8/11/23 and 8/16/23. An observation was made of Resident 140 on 8/18/23 at 11:08 a.m. The resident was observed with gray hair on her chin and her hair was greasy with white flakes. She indicated at that time, she still had not received a shower. 3.1-38(2)(a)(3)(B)		will be conducted 2 times a week times 4 weeks, 1 time a week times 4 weeks, every 2 weeks times 3 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. 5. Date of completion: 9/22/23	
F 0684 SS=E 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 prime an insulin flex pen prior to administering insulin for 1 of 5 residents observed during administration of medications, ensure monitoring of bowel and bladder outputs for 1 of 2 residents reviewed for hospitalization and 1 of 1 residents reviewed for constipation, and to administer antibiotics, as ordered by a physician, for 1 of 1 resident reviewed for dental (Residents' 2, 9, 35 and 142) Findings include: 1. The clinical record for Resident 35 was reviewed on 8/21/23 at 9:00 a.m. The diagnosis for Resident 35 included, but was not limited to, diabetes mellitus type 2. A physician order indicated the resident was to receive a sliding scale of insulin aspart. The sliding scale was the following: blood sugar reading of 151 to 200 = 3 units, blood sugar reading of 201 to 250 = 5 units, blood sugar reading of 251 to 300 = 8 units, blood sugar reading of 301 to 350 = 10 units, and blood sugar reading of 351 to 400 = 12 units, An observation was made of a medication administration with License Practical Nurse (LPN) 6 on 8/21/23 at 11:22 p.m. LPN 6 was observed preparing to administer insulin utilizing a flexpen	F 0684	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? • Resident 2 no longer requires antibiotics. • Resident 9’s medical condition has returned to baseline. • Resident 35’s insulin is being administered per order. • Resident 142’s constipation has resolved. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. ¿ All like residents have the potential to be affected by the alleged deficient practice. DHS or designee to educate nursing staff on Medication Administration General Guidelines, Guidelines for Bowel Protocol, Guidelines for Electronic ADL Documentation, and the process of preparing and insulin pen for use. 3: What measures will be put into place or what systemic changes	09/22/2023

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	to Resident 35. LPN 6 pulled an aspart insulin flexpen and placed a needle on it. LPN 6 then administered 3 units of aspart insulin to the resident. There was no observation of priming the flexpen prior to administration of the 3 units. An interview was conducted with Pharmacist 20 on 8/21/23 at 1:22 p.m. He indicated the flex pens should be primed 2 units of insulin prior to dial up the insulin amount to be given. "Novolog (insulin aspart injection) flextouch" manufacture instructions at website www.novologpro.com dated 2/2023, was retrieved on 8/22/23. It indicated "..Prescribing information...Priming your novolog flextouch pen:..Step 7: Turn the dose selector to select 2 units...Step 8: Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top..Step 9: Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows "0". The "0" must line up with the dose pointer. A drop of insulin should be seen at the needle tip... If you do not see a drop of insulin, repeat steps 7 to 9, no more than 6 times.. If you still do not see a drop of insulin, change the needle and repeat steps 7 to 9..." 2. The clinical record for Resident 9 was reviewed on 8/16/23 at 2:00 p.m. The diagnosis for Resident 9 included, but was not limited to, kidney disease. A medical provider progress note dated 5/24/23 indicated "Chronic kidney disease...monitor renal function closely." A medical provider progress note dated 6/8/23 indicated the resident was being seen that day due to recent hospitalization for "acute respiratory		will be made to ensure that the deficient practice does not recur? ¿ DHS or designee will be responsible for auditing residents receiving insulin pen injections to ensure procedure is performed correctly. An audit of 5 residents will be conducted 2 times a week times 4 weeks, 1 times a week times 4 weeks, every 2 weeks times 3 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. ¿ DHS or designee will be responsible for auditing documentation of resident urine outputs. An audit of 5 residents will be conducted 2 times a week times 4 weeks, 2 times a week times 4 weeks, 1 time a week x4 weeks, every 2 weeks times 3 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. ¿ DHS or designee will be responsible for auditing documentation of resident bowel movements to ensure bowel protocol is utilized when appropriate. An audit of 5 residents will be conducted 2	

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	failure with hypoxia, hypertensive urgency, and new onset volume overload....Stage III chronic kidney disease, Monitor urinary output..." A June 2023 urine output report was provided by the Director of Nursing on 8/21/23 at 10:54 a.m. It indicated the following days urine output was not recorded for Resident 9: 6/1/23, 6/8/23, 6/9/23, 6/10/23, 6/11/23, 6/12/23, 6/13/23, 6/14/23, 6/15/23, 6/16/23, 6/19/23, 6/20/23, 6/21/23 and 6/23/23. An interview was conducted with Nurse Consultant (NC) 2 on 8/21/23 at 2:45 p.m. She indicated she was unable to provide any additional urine outputs for the missing days from the June 2023 urine output report. 3. The clinical record for Resident 142 was reviewed on 8/16/23 at 2:00 p.m. The diagnoses for Resident 142 included, but were not limited to, constipation and cerebral palsy. The resident was admitted on 8/11/23. The discharge paperwork dated 8/11/23 indicated the resident was receiving daily fleet enemas due to constipation. A baseline care plan dated 8/11/23 indicated the "Resident will maintain or improve present bowel and bladder..." The bowel report for Resident 142 indicated the resident had not had bowel movement on 8/12/23, 8/13/23, 8/14/23, 8/15/23, 8/16/23 and 8/17/23. A physician order dated 8/11/23 indicated Resident 142 was to receive a fleet enema once a day.		times a week times 4 weeks, 2 times a week times 4 weeks, 1 time a week x4 weeks, every 2 weeks times 3 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED ¿ DHS or designee will be responsible for auditing residents with new antibiotic orders to ensure medications are administered as ordered. An audit of 5 residents will be conducted 2 times a week times 4 weeks, 2 times a week times 4 weeks, 1 time a week x4 weeks, every 2 weeks times 3 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The	

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	A physician order dated 8/11/23 indicated Resident 142 was to receive 8.6 milligrams of senna. A physician order dated 8/11/23 indicated if resident had not a bowel movement within 72 hours 2 tablespoons of natural laxative would be provided. The August 2023 Medication/Treatment (MAR/TAR) record for Resident 142 indicated the resident was to receive a fleet enema once a day between 6:00 a.m. - 10:00 a.m. The resident did not receive the fleet enema on 8/15/23, because of availability of medication and 8/17/23 between 6:00 a.m. -10:00 a.m., because resident was unavailable. The resident's clinical record did not indicate the staff was providing additional monitoring of the resident's lack of bowel movements since admission of 8/11/23. An interview was conducted with Nurse Consultant (NC) 1 on 8/17/23 at 2:03 p.m. She indicated Resident 142's food consumption was minimal, and he was admitted with receiving fleet enemas daily with senna. A KUB would be ordered. An Registered Dietcian note dated 8/16/23 indicated Resident 142's "meal consumption ranging from refusal to 51-100%." An interview was conducted with NC 2 on 8/18/23 on 8/18/23 at 3:13 p.m. She indicated the resident's scheduled fleet enema was moved to be provided in the evenings from 6:00 p.m. - 10:00 p.m. as of 8/17/23. The resident had received a fleet enema that evening.		plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. 5. Date of completion: 09/22/23	

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	A bowel protocol guidelines policy was provided on 8/18/23 at 2:57 p.m. It indicated "...Purpose. To provide guidance for the use of bowel stimulants for residents with constipation. Procedures. 1. Upon admission, an order may be obtained to 'utilize bowel protocol as needed.' 2. If the resident needs to utilize the bowel protocol, the 'Bowel Protocol' order set may be opened and orders entered from order set. 3. The ineffective bowel pattern event should be initiated for any resident not having a BM [bowel movement] within 72 hours (unless this has been determined to be a usual bowel pattern for the individual). a. A progress note associated to the ineffective bowel event, should be completed until the resident has a BM or the bowel pattern returns to normal for the resident. The progress note should include abdominal distention, pain and bowel sounds. 4. Nursing staff shall assess for effectiveness, orders may be written as follows; a. if no bowel movement within 72 hours, 2 tablespoons...of 'Natural Laxative' b. If no results within 24 hours, after 'natural laxative' give 30 cc [cubic centimeters/milliliters] of Milk of Magnesia c. If no results within approximately 12 hours after MOM administer Dulcolax suppository. d. If results of suppository are not satisfactory within 2 hours give Fleet enema. 5. IF at any time there are indications of a bowel blockage the physician should be notified to receive instructions to proceed with the protocol or to intervene with further testing..." 4. The clinical record for Resident 2 was reviewed on 8/16/23 at 1:30 p.m. The Resident's diagnosis included, but were not limited to, dementia and dysphagia (difficulty swallowing). She was admitted from an acute care hospital to the facility on 7/7/23. Resident 2 resided in the facilities attached memory care assisted living prior to her			

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	hospitalization. A nursing progress note, dated 7/24/23 at 1:46 a.m., indicated that Resident 2's appetite and oral intake remained poor. Resident 2 periodically complained of mouth and tooth pain. Resident 2 is unable to use a straw for liquids due to cognition deficit and potential tooth pain. A physician's progress noted, written by NP (Nurse Practitioner) 30 on 7/24/23 at 12:26 p.m., indicated that Resident 2 was being seen as a follow up to the acute log report of mouth pain. A second round of Augmentin was started. A care plan, initiated 7/25/23, indicated Resident 2 had the potential for mouth pain related to abscess and tooth decay per daughter's report. The goal was for her not to exhibit mouth pain or infection. The interventions, initiated 7/25/23, included but were not limited to, encourage fluids, offer and provide mouth care as needed, administer medications as ordered, and dental evaluation and interventions as needed The July 2023 MAR did not contain documentation that Augmentin, ordered on 7/24/23, was given at all. On 8/18/23 at 3:40 p.m. NP 30 and NP Compliance Officer 33 were interviewed. NP 30 indicated she had intended for Resident 2 to receive a second round of Augmentin on 7/24/23 to treat her oral abscess and for a possible urinary tract infection. She was unaware it had not been given. NP Compliance Officer 33 indicated that the 7/24/23 Augmentin order had been written in Resident 2's Assist Living chart in error. During an interview on 8/21/23 at 1:25 p.m.,			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Pharmacist 20 indicated that the 7/24/23 order for Augmentin had been filled. There had been 14 tablets of Augmentin delivered to the 200 hall of the facility on 7/24/23. Seven of the Augmentin tablets had been returned to the pharmacy. 3.1-37			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to implement care planned fall intervention and to include therapy recommendations to the care plan for 1 of 1 resident reviewed for accidents. (Resident 29) Findings include: The clinical record for Resident 29 was reviewed on 8/16/23 at 2:11 p.m. The Resident's diagnosis included, but were not limited to, Huntington's disease (disease of nervous system) and history of falling. A care plan, initiated 2/24/22, indicated he was at risk for falling related to his impaired cognition, restlessness, and exit seeking. The goal was for him to remain free from falls with major injury. The	F 0689	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? • Resident 29 has fall interventions in place per plan of care. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. ¿ Residents with falls have the potential to be affected by the alleged deficient practice. DHS or designee to educate nursing staff on the Fall Management Program Guidelines.	09/22/2023

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	155815	A. BUILDING 00 B. WING	08/22/2023

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	approaches were to have fall mat at bedside, initiated 6/28/23, footboard to bed to assist with boundaries, initiated 5/15/23, staff to offer to lay resident down after meals upon request, initiated 8/16/23, provide sandwich/snack around midnight hours if awake, initiated 5/12/2023, offer to toilet after dinner, initiated 4/24/2023, ensure resident is given everything he needs before he lays down, initiated 4/10/2023, encourage/assist resident with after dinner activity, initiated 1/18/2023, offer activity of choice prior to evening meal, initiated 11/22/2022, dycem (material that prevents sliding) to wheelchair, initiated 11/16/2022, therapy referral to assess for WC positioning, initiated 11/07/2022, offer bedtime snack prior to retiring for the night, initiated 8/30/2022, anti-tippers (devices which decrease risk of wheelchair tipping backward) to wheelchair, initiated 7/27/2022, bed to be in lowest position, initiated 2/24/2022, therapy eval and treat as needed, initiated 2/24/2022, staff to assist with transfers as needed, initiated 2/24/2022, and encourage/assist resident to assume a standing position slowly, initiated 2/24/2022. An Occupational Therapy Discharge Summary, dated 5/4/23, indicated Resident 29 had been treated for optimal upright sitting posture in a modified wheelchair with most appropriate positioning devices and supports for reduced fall risk. Upon discharge from therapy, Resident 29 was demonstrating upright sitting posture with midline trunk alignment while seated in a standard height wheelchair with a pommel cushion (positioning cushion), dycem, anti-rollbacks (device which prevents wheels from rolling), anti-tippers and brightly colored left and right brakes. The treatment results and plan were communicated to the Interdisciplinary team.		3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ¿ DHS or designee will be responsible for auditing residents with falls to ensure interventions are in place. An audit of 5 residents will be conducted 2 times a week times 4 weeks, 2 times a week times 4 weeks, 1 time a week x4 weeks, every 2 weeks times 3 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED/DHS/ADHS/Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue	

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	A physician's order, dated 6/8/23, indicated Resident 29 was to be up in his wheelchair with a pommel cushion, anti-rollbacks, and anti-tippers as tolerated. He required assist x 2 from staff for all functional transfers. The fall care plan had not been updated with the addition of the pommel cushion, anti-rollbacks, brightly colored left and right brakes, or the need for 2 staff with transfers. A Quarterly MDS (Minimum Data Set) Assessment, completed 7/7/23, indicated Resident 29 was severely cognitively impaired. He required extensive assist of 2 staff members for transfers and had a history of 2 or more falls without injury during the assessment period. On 8/16/23 at 2:11 p.m., Resident 29 was observed sitting on his bottom on the floor in his room with his sweatpants at his knees. He had a sandal on one foot and a sock on the other foot. LPN (Licensed Practical Nurse) 7 was coming down the hallway from the nursing station to assist Resident 29 and upon reaching his room indicated to him that she knew what he was trying to do, he was trying to get into bed. On 8/16/23 at 2:16 p.m., Resident 29 was observed sitting in his wheelchair on a pommel cushion. He was being brought to the nursing station. On 8/17/23 at 1:31 p.m., Resident 29 was observed sitting by his bed in his wheelchair. On 8/18/23 at 11:07 a.m., Resident 29 was observed in his bed. His wheelchair was against the wall at the bottom of his bed. The metal bar for the anti-roll back device was missing from the wheelchair.		past 6 months if warranted until 100% compliance met. 5. Date of completion: 9/22/23	

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	On 8/18/23 at 2:12 p.m., Resident 29 was observed with LPN 22. Resident 29 was laying in bed and his wheelchair was located against the wall a crossed from the foot of his bed. The anti-rollback bar on the left side of his wheelchair was not present. LPN 22 indicated she believed that there was only one anti-roll back bar present so that Resident 29 could still turn. LPN 22 demonstrated that the anti-rollback bar could be lifted so that the wheelchair would roll backwards. On 8/10/23 at 3:05 p.m., Resident 29's room was observed with CNA (Certified Nursing Assistant) 37. Resident 29's wheelchair was not in the room. CNA 37 indicated it had been taken to be fixed. CNA 37 was not sure what was broken on the wheelchair. On 8/18/23 3:10p.m., Resident 29's wheelchair was observed in the maintenance department with the Maintenance Director and the Director of Nursing. The Maintenance Director indicated that he was fixing the anti-rollback devices. When he had removed the items from the wheelchair, dysem had not been present in the seat of the wheelchair. He was not sure how long it had been broken. On 8/21/23 at 10:54 a.m., the Director of Nursing provided the Falls Management Program Guidelines, last reviewed 3/16/22, which read "...strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures...4. Any orders received from the physician should be noted and carried out. 5. The resident care plan should be updated to reflect any new or change in interventions..." 3.1-45(a)(2)			

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F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to coordinate a resident's medication administration times with their dialysis schedule and complete post dialysis assessments, as ordered, for 1 of 1 resident reviewed for dialysis. (Resident 14) Findings include: The clinical record for Resident 14 was reviewed on 8/21/23 at 3:06 p.m. His diagnoses included, but were not limited to, end stage renal disease. The dialysis care plan, last reviewed/revised 8/21/23, indicated an approach was to coordinate care with the dialysis center. His dialysis days were Tuesday, Thursday, and Saturday. An observation of Resident 14's room was made on Tuesday, 8/22/23, at 10:30 a.m. He was not present in his room. An interview was conducted with LPN (Licensed Practical Nurse) 6 on 8/22/23 at 10:31 a.m. He indicated Resident 14 was currently at dialysis and usually returned between 11:00 a.m. and 12:00 p.m. The physician's orders indicated to administer one 500 mg tablet of Tylenol Extra Strength three times a day, starting 12/14/20; one 25 mg tablet of	F 0698	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? • Resident 14's medication times have been adjusted. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. ¿ All residents receiving dialysis have the potential to be affected. DHS or designee to educate nursing staff on Guidelines for Dialysis. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ¿ DHS or designee will audit residents receiving dialysis to ensure medication administration times are adjusted around dialysis and that post dialysis assessments are documented. An audit of 5 residents will be conducted 2 times a week times 4 weeks, 1 times a week times 4	09/22/2023

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	Sertraline once a day, starting 8/9/21; one 30 mg tablet of Sensipar once a day, starting 3/17/23; one 20 mg capsule of Omeprazole once a day, starting 12/22/22; provide Nepro 237 ml twice daily as a supplement, started 3/3/22; and complete the Dialysis Center Communication Observation on his dialysis days of Tuesday, Thursday and Saturday. The August, 2023 MAR (medication administration record) indicated the following medications and supplement were not administered on the following dates due to him being unavailable between 6:00 a.m. and 10:00 a.m. on a Tuesday, Thursday, or Saturday: Omaprazole on 8/1/23, 8/3/23, 8/8/23, 8/10/23, and 8/15/23; Sensipar on 8/1/23, 8/3/23, 8/8/23, 8/10/23, and 8/15/23; Sertraline on 8/1/23, 8/3/23, 8/8/23, 8/10/23, and 8/15/23; Nepro on 8/1/23, 8/3/238/5/23, 8/8/23, 8/10/23, 8/15/23, and 8/19/23; and Tylenol Extra Strength on 8/1/23, 8/3/23, 8/5/23, 8/8/23, 8/10/23, 8/15/23, and 8/19/23. An interview was conducted with the DON (Director of Nursing) on 8/22/23 at 3:45 p.m. She indicated Resident 14's medications should be scheduled around his dialysis schedule. The August, 2023 TAR (treatment administration record) indicated the Dialysis Center Communication Observation was completed on the following dates: 8/1/23, 8/3/23, 8/5/23, 8/15/23, 8/17/23, and 8/19/23. The Dialysis Center Communication Observation assessments for 8/1/23, 8/3/23, 8/5/23, 8/15/23, 8/17/23, and 8/19/23 did not have the Assessment Upon Return From Dialysis section completed. This section included the general condition of the resident, the condition of the shunt, whether there were new orders from the dialysis center, and the resident's		weeks, every 2 weeks times 3 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED/DHS/ADHS or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. 5. Date of completion: 9/22/23	

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	temperature, pulse, respirations, blood pressure, and oxygen saturation. An interview was conducted with LPN 6 and the ADON (Assistant Director of Nursing) on 8/22/23 at 10:31 a.m. LPN 6 indicated Resident 14 was assessed upon return from dialysis, which was usually between 11:00 a.m. and 12:00 p.m. The assessments included things like his blood pressure, temperature, and respirations, which were documented in the Assessment Upon Return From Dialysis section of the Dialysis Center Communication Observation. They did not document this post dialysis assessment anywhere else. The ADON indicated the assessment also included whether the resident had a change in condition, a medication change, and the condition of his shunt site. The Guidelines for Dialysis policy was provided by the ED (Executive Director) on 8/17/23 at 11:30 a.m. It read, "PURPOSE...To provide communication to Dialysis Providers and monitoring of resident receiving dialysis....Upon return from the Dialysis Provider the campus shall: a. Provide ongoing monitoring of the shunt site for signs of complication." 3.1-37(a)			
F 0790 SS=G Bldg. 00	483.55(a)(1)-(5) Routine/Emergency Dental Srvcs in SNFs §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an			

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	outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. Based on observation, interview and record review, the facility failed to timely assist in arranging emergency dental services for a resident with an abscessed tooth resulting in a delay of dental services for the abscessed tooth which was painful and infected 1 of 1 Resident reviewed for Dental (Resident 2).	F 0790	An IDR is requested for this deficiency. Key factors: • Dentist notes shows no change from 2021 to 2023. X-ray results included with no infection noted. Tooth #13 monitored with each visit and continued to be asymptomatic.	09/22/2023

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	Findings include: The clinical record for Resident 2 was reviewed on 8/16/23 at 1:30 p.m. The Resident's diagnosis included, but were not limited to, dementia and dysphagia (difficulty swallowing). She was admitted from an acute care hospital to the facility on 7/7/23. Resident 2 resided in the facilities attached memory care assisted living prior to her hospitalization. A nursing progress note, dated 7/9/23 at 6:17 p.m., indicated a family member informed staff member that Resident 2 was to have oral surgery prior to her hospitalization. Resident 2 had multiple teeth which needed extracted. A follow up appointment needed to be scheduled as soon as possible. An assessment of Resident 2 revealed pain to mouth and throat and a large, abscess-like area along the gum line on the bottom left side of her mouth. A physician's progress note, dated 7/10/23 at 11:29 a.m., indicated Resident 2 had a possible dental abscess. Her right jaw showed as to be painful and mildly swollen. Augmentin (antibiotic) was started and an order for urgent outpatient dental appointment was written. A physician's order, dated 7/10/23, read as written "URGENT: DENTIST TO EVAL AND TREAT FOR POTENTIAL ABSCESS." The order was discontinued on 7/14/23. There was no documentation in the clinical record that a dental appointment had been scheduled or that the Resident 2's POA (Power of Attorney) had been contacted about dental services. A physician's order, dated 7/10/23, read "amoxicillin-pot[sic] clavulanate [Augmentin]		• Residents' family/POA wished for resident to be seen in house and not external dental facility. • Campus was in communication with dentist and pain management was in place and effective. Family was notified throughout the process and resident was seen per the provider throughout the process. • Resident's weight was stable and PO intake was unchanged upon admission. • Resident was followed by registered dietician throughout her stay and weight remained stable. Continued consistent intake in hospital and once admitting to the campus as well as stable weights throughout the observation period. Orders obtained and supplements in place. 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? • Resident 20's dental concern has resolved. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. ¿ Residents with dental abscess have the potential to be affected. ED or designee to educate IDT team on the	

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	tablet; 875-125 mg[milligram]; 1 tablet; oral DX [sic] periapical [dental] abscess without sinus] Twice a Day...". The order was discontinued on 7/17/23. An Admission MDS (Minimum Data Set) Assessment, completed 7/13/23, indicated Resident 2 was severely cognitively impaired, needed extensive assistance of 2 staff members to transfer, and had no dental concerns present. A physician's order, dated 7/14/23, read as written "SCHEDULE A DENTIST TO EVAL[SIC] AND TREAT FOR POTENTIAL ABCESS. Special Instructions: may d/c[sic] order when completed..." The order was discontinued on 7/18/23. A social services note, dated 7/15/23 at 1:44 p.m., indicated that a Resident 1st meeting was held and that hospice services were discussed. The POA (Power of Attorney) wanted to continue therapy for a few more weeks and see progress before making a decision about hospice. Plan of care is in place with no changes made. The meeting notes did not indicate that Resident 2's tooth pain was addressed during the meeting. A nursing progress note, dated 7/18/23 at 1:07 p.m., read "writer notified family in regards of setting up dental appt[sic] family made aware will schedule appt [sic] will continue to monitor." A nurse practitioner progress note, dated 7/18/23 at 1:20 p.m., indicated Resident 2 was being seen to evaluate condition after antibiotic therapy. No record of dental appointment. Resident 2 was an unreliable historian. When she was asked, she denied jaw pain.		requirements for obtaining emergency dental services. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ¿ ED or designee will be responsible for auditing residents with dental abscess to ensure services are offered timely. An audit of 5 residents will be conducted 3 times a week times 4 weeks, 2 times a week times 4 weeks, 1 time a week x4 weeks, every 2 weeks times 3 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will	

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	A nursing progress note, dated 7/24/23 at 1:46 a.m., indicated that Resident 2's appetite and oral intake remained poor. Resident 2 periodically complained of mouth and tooth pain. Resident 2's family stated that she is to be seen by the facility dentist in preparation for a potential tooth extraction. Resident 2 is unable to use a straw for liquids due to cognition deficit and potential tooth pain. A physician's progress noted, written by NP (Nurse Practitioner) 30 on 7/24/23 at 12:26 p.m., indicated that Resident 2 was being seen as a follow up to the acute log report of mouth pain. There was still no word on outpatient dental appointment. A second round of Augmentin was started. A care plan, initiated 7/25/23, indicated Resident 2 had the potential for mouth pain related to abscess and tooth decay per daughter's report. The goal was for her not to exhibit mouth pain or infection. The interventions, initiated 7/25/23, included but were not limited to, encourage fluids, offer and provide mouth care as needed, administer medications as ordered, and dental evaluation and interventions as needed. A physician's order, dated 7/25/23, indicated she was to receive tramadol (pain medication) 25 mg twice daily for pain and every 4 hours as needed for pain. A nursing progress note, written by the DON (Director of Nursing) on 7/25/23 at 12:35 p.m., indicated the Nurse Practitioner was aware of mouth and tooth pain with a new order for tramadol (pain medication) 25 mg twice daily. and every 4 hours as needed for pain. The family member was at the facility for a meeting and was		decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. 5. Date of completion: 09/22/23	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLEARVISTA LAKE HEALTH CAMPUS	8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256

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	aware of the new order. A physician's progress note, written by NP 30 on 7/25/23 at 1:37 p.m., indicated Resident 2 was on the acute log again due to mouth pain. Augmentin restarted yesterday. Resident 2 was on the list to be seen by in-house dentist. The Dental Provider Note, dated 7/25/23, indicated Resident 2 had a limited exam for pain on the left upper side. X-rays were taken to confirm. The recommendation is extraction of this tooth. The dental provider could try to extract in house, if approved by the resident representative, the tooth could be extracted in the facility. The dental provider also sent a referral for her to be sent out for extraction, so that Resident 2 would be covered for either scenario. A physician's progress note, written by NP 30 on 7/31/23 at 10:53 a.m., indicated Resident 2 was being seen as a follow up for the end of antibiotic therapy. The staff reports that resident is on the list to be seen by the in-house dentist this week. We will continue to monitor closely. The July MAR (Medication Administration Record) indicated that the Augmentin, ordered on 7/10/23, had been administered as ordered, with the exception of refused evening dose on 7/10/23. The July 2023 MAR did not contain documentation that Augmentin, ordered on 7/24/23, was given at all. A social services progress note, dated 8/1/23 at 9:03 a.m., indicated that had Resident 2 had expressed mouth pain. Antibiotics had been started by the physician to help eliminate any signs or symptoms of infection and to reduce			

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	pain. The POA (Power of Attorney) was offered an opportunity for resident to be sent out to dental services within the community for a prompt resolution. The POA expressed that due to Resident 2's physical and mental decline, an in-house dentist was preferred. The dental group provided an emergency visit on 7/25/23. Consents for in house services were signed and sent back to the dental group on 7/28/23. Awaiting confirmation of upcoming appointment. A nursing progress note, dated 8/4/23 at 5:06 p.m., indicated Resident 2 now on routine pain medication as she is unable to express discomfort. She has flaccid facial expressions with no indicator of pain. A Physicians order, dated 8/4/23, indicated Resident 2 was to receive tramadol 25 mg at 8 a.m., 12 p.m., 4 p.m., and 8 p.m. for pain and may receive tramadol 25 mg as needed twice daily for pain. A nursing progress note, dated 8/5/23 at 9:14 p.m., indicated Resident 2 had very poor oral intake during the shift. A Family Member at bedside earlier in the shift had expressed concerns regarding teeth extractions. A social services progress note dated 8/7/23 at 12:04 p.m. read "Writer contacted in house dental group, regarding emergency scheduling of extractions for resident. Upon last contact made, appointment would be scheduled, and writer was to be made aware of date/[sic] time. As of today, writer had received no updated information. Upon contact with clinical support manager, next available appointment is 8/22/23. Writer requested that clinical support manager supervisor make contact in efforts to find opportunities of an earlier visit date as resident is			

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	exhibiting pain and discomfort related to tooth. Writer currently awaiting return call/[sic] email from supervisor related to scheduling. POA [sic] made aware. Pain medications have been reviewed and ATB [sic] treatment ordered and in place to provide resident with comport and relief. A physician's order, dated 8/7/23, indicates Resident 2 was to receive amoxicillin- pot clavulanate (Augmentin) 875-125 mg tablet twice daily for pain. A physician's progress note, written by NP 30 on 8/15/23 at 12:37 p.m., indicated that on 8/7/23, Resident 2 continued to complain of mouth pain. Has been decreasing oral intake due to pain. The social worker to get dentist here as soon as possible. Will restart Augmentin while awaiting dental intervention. On 8/15/23, complaints of pain today. Will begin oral saline rinse in the morning, after food intake, and at bedtime. She is on the list to be seen by in-house dentist. On 8/17/23 at 1:30 p.m., Resident 2 was observed sitting in the common area with a staff member. Her teeth were noted to be dark brown in color. During an interview on 8/18/23 at 12:30 p.m., FM (Family Member) 31 indicated that Resident 2's dental issues had been going on for a long time. Resident 2 had complained that her teeth were bothering her and she was scheduled to have some teeth extracted prior to leaving the Assisted Living part of the facility but had been hospitalized prior to having it done. When she was admitted to the facility on 7/7/23 she was complaining of tooth pain. FM 31 was not offered the option of having Resident 2 see an inside dentist when she was admitted to the facility on			

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	7/7/23 and had not declined in house services for dental care upon admission. FM 31 was unable to transfer Resident 2 to a dental chair and was not sure how she would get Resident 2 to the oral surgeon because it took two people to transfer her. FM 31 did not know what else to do about getting a dental appointment. FM 31 had made the facility aware of the need for a dental visit on several occasions and had received no direction, which was frustrating. The facility started her on an antibiotic and Tylenol and the pain got better. On around 7/22/23 Resident 2 started to say that her teeth hurt again. The antibiotic course was over. During a meeting on 7/25/23, FM 31 had told SSD that Resident 2's teeth were hurting again, and the DON came into the meeting to discuss pain medication options. The facility ordered some pain medication for her to help with the tooth pain. The facility offered an inside dentist to see Resident 2 and she was seen on 7/25/23. FM 31 had given verbal permission to the dental provider for them to provide treatment in house, over the phone on 7/27/23 and had signed a consent for dental treatment on 7/28/23. During an interview on 8/18/23 at 1:50 p.m., the SSD indicated that in house dental services are normally offered upon admission and at the Resident First meeting. The consent would be signed and faxed to the provider. On 8/18/23 at 3:40 p.m. NP 30 and NP Compliance Officer 33 were interviewed. NP 30 indicated she had written the 7/10/23 order for Resident 2 to be seen by the dentist. She had written another order on 7/14/23 for Resident 2 to have a dental consult because she had not heard any updates from the facility on if the appointment was scheduled and NP 30 had been aware the family had wanted in house dental services. NP 30 had			

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	intended for Resident 2 to receive a second round of Augmentin on 7/24/23 to treat her oral abscess and for a possible urinary tract infection. She was unaware it had not been given. NP Compliance Officer 33 indicated that the 7/24/23 Augmentin order had been written in Resident 2's Assist Living chart in error. During an interview on 8/21/23 at 1:25 p.m., Pharmacist 20 indicated that the 7/24/23 order for Augmentin had been filled. There had been 14 tablets of Augmentin delivered to the 200 hall of the facility on 7/24/23. Seven of the Augmentin tablets had been returned to the pharmacy. Resident 2 had resided on the 200-hall portion of the facilities Assisted Living, which was connected to the health center unit Resident 2 was admitted to on 7/7/23. Resident 2's tooth was extracted at the facility on 8/22/23. During an interview on 8/24/23 at 1:13 p.m., Dental Provider Scheduler 38 indicated that the first time the facility contacted the in-house dental provider to arrange a dental exam was 7/21/23. The Dental Provider had a Dentist in the facility on 7/21/23, but the triage form had been received by the dental provider after the dentist had already left the facility. If the facility had reached out sooner, Resident 2 could have been seen for her initial triage appointment on 7/21/23, and a treatment plan could have been started. Resident 2 was seen by a Dentist for a triage appointment on 7/25/23 and a treatment plan was set up at that time. When a tooth is abcessed it is normally very uncomfortable for the patient due to the pain and pressure from the infection.			

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	During an interview on 8/18/23 at 2:06 p.m., the Executive Director indicated the facility did not have a specific dental policy, the facility followed the regulation. 3.1-24(a)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review the facility failed to serve pureed food at appropriate temperatures with the potential to affect 7 of 37 residents residing at the facility. Findings include: The lunch service was observed with the Dietary	F 0812	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? • 7 residents received pureed food that was not served at appropriate temperature. No residents had no ill effects from this.	09/22/2023

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	Manager on 8/18/23 at 11:42 a.m. The pureed food temperatures were obtained while the food was on the steam table for service. The pureed ham was 102 degrees Fahrenheit, the pureed sweet potatoes were 100 degrees Fahrenheit, and the pureed greens were 100 degrees Fahrenheit. During an interview at 11:50 a.m., the Dietary Manager indicated the temperature at serving should be at least 145 degrees Fahrenheit. The pureed meal had already been served to a couple of residents. It would be reheated. The pureed meal had been 171 degrees Fahrenheit when it was removed from the oven. There should have been a cover over the food to assist in maintaining the temperatures. During an interview on 8/21/23 at 11:36 a.m., Nurse Consultant 2 indicated there were 7 residents of the health center who received a pureed diet. 3.1-21(a)(2)		2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. • All resident with orders for pureed foods have the potential to be affected. DFS or designee will inservice dietary staff on Food Safety and Handling policy. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ¿ DFS or designee will be responsible for auditing pureed food temperature during meal service. An audit of 5 residents will be conducted 3 times a week times 4 weeks, 2 times a week times 4 weeks, 1 time a week x4 weeks, every 2 weeks times 3 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent	

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			corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. 5. Date of completion: 09/22/23	
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, visitors, and other individuals providing services under a contractual arrangement			

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	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 facility.			

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	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure infection control was maintained during medication administration for 1 of 5 residents observed during medication administration and failed to ensure urinary catheter tubing and drainage bags were not touching the floor for 1 of 1 resident reviewed for urinary catheter. (Resident 2 and 35) Findings include: 1. The clinical record for Resident 35 was reviewed on 8/21/23 at 9:00 a.m. The diagnosis for Resident 35 included, but was not limited to, diabetes mellitus type 2. A physician order indicated the resident was to receive a sliding scale of insulin aspart. The sliding scale was the following: blood sugar reading of 151 to 200 = 3 units, blood sugar reading of 201 to 250 = 5 units, blood sugar reading of 251 to 300 = 8 units, blood sugar reading of 301 to 350 = 10 units, and blood sugar reading of 351 to 400 = 12 units An observation was made of a medication administration with License Practical Nurse (LPN) 6 on 8/21/23 at 11:22 p.m. LPN 6 was observed preparing to administer insulin utilizing a flexpen to Resident 35. LPN 6 pulled a insulin aspart flexpen and placed a needle on it. There was no	F 0880	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? • Resident 35 received his insulin with no ill effects. • Resident 2's catheter tubing adjusted to not touch the floor. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. • All like residents have the potential to be affected. DHS or designee will re-educate the nursing staff on preparing an insulin pen for use and the Catheter Care Guidelines. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ¿ DHS or designee will be responsible for auditing residents with insulin pens to ensure administered correctly. An audit of 5 residents will be conducted 2 times a week times 4 weeks, 1	09/22/2023

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	observation of disinfecting the rubber top of the flexpen utilizing an alcohol wipe prior to placement of the needle to the flexpen. LPN 6 then administered 3 units of humalog insulin to the resident. An interview was conducted with Nurse Consultant (NC) 2 on 8/21/23 at 3:37 p.m. She indicated the needles that are placed on the flexpens disinfect the rubber top, so the staff does not need to use an alcohol wipe to disinfect the rubber top of the flexpen prior to needle placement. An interview was conducted with Nurse Consultant 2 on 8/22/23 at 10:56 a.m. She was unable to locate documentation to support the needle will disinfect the rubber top after placement on the flex pen. An injectable medication administration facility policy was provided by the NC 2 on 8/21/23 at 3:37 p.m. It indicated "...Specific medication administration procedures...Clean stopper with alcohol pad and allow to air dry (Except on pen devices and pre-filled syringes)..." "Novolog (insulin aspart injection) flextouch" manufacture instructions at website www.novologpro.com dated 2/2023, was retrieved on 8/22/23. It indicated "...Preparing your Novolog Flexpen...A. Pull off the pen cap...Wipe the rubber stopper with an alcohol swab. Attaching the needle..." 2. The clinical record for Resident 2 was reviewed on 8/16/23 at 1:30 p.m. The Resident's diagnosis included, but were not limited to, dementia, dysphagia (difficulty swallowing), and neurogenic bladder.		times a week times 4 weeks, every 2 weeks times 3 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. ¿ DHS or designee will be responsible for auditing residents with catheters to ensure tubing is not touching the floor. An audit of 5 residents will be conducted 2 times a week times 4 weeks, 1 time a week times 4 weeks, every 2 weeks times 3 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased	

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	An Admission MDS (Minimum Data Set) Assessment, completed 7/13/23, indicated Resident 2 was severely cognitively impaired and had a urinary catheter present. A care plan, initiated 7/19/23, indicated Resident 2 used a foley catheter due to her diagnosis on neurogenic bladder. The goal was for her to be free from adverse effects of catheter use. The interventions, initiated 7/19/23, included but were not limited to maintain a closed system with urinary bag below the resident's bladder and covered and observe tubing and avoid any obstructions. On 8/16/23 at 1:30 p.m., Resident 2 was observed sitting in her wheelchair at the nurse's station with LPN 35. Resident 2's urinary catheter tubing was looped beneath her chair and touching the floor. On 8/17/23 at 9:44 a.m., Resident 2 was observed sitting in her wheelchair at the nursing station with LPN 11. Resident 2's urinary catheter tubing was looped beneath her chair and touching the floor. On 8/17/23 at 1:55 p.m., Resident 2 was with the Director of Nursing. Resident 2 was laying in bed. Her bed was in a low position and a floor mat was present in front of her bed. Her catheter drainage bag was touching the floor mat. During an interview on 8/17/23 at 1:55 p.m., the Director of Nursing indicated that the catheter bag should not be touching the floor mat. On 8/17/23 at 3:21 p.m., NC 1 provided the Urinary Catheter Care policy, last reviewed on 12/31/22, which read "...11. Be sure the catheter tubing and drainage bag are kept off of the floor..."		concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. 5. Date of completion: 09/22/23	

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F 9999 Bldg. 00	3.1-18 3.1-14 Personnel ...(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method. (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure 2nd step TB (tuberculin) testing was completed for 5 of 10 staff members reviewed for TB testing. (LPN-Licensed Practical Nurse 7, CNA-Certified Nursing Assistant 8, CNA 9, CNA 10, and Maintenance Director) Findings include: The Employee Records form was provided by the ED (Executive Director) on 8/17/23 at 8:50 a.m. They indicated LPN 7 began working at the facility on 2/7/23. CNA 8 began working at the facility on 7/18/23. CNA 9 began working at the	F 9999	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? • The 5 staff members received TB skin testing. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. • All new hire employees have the potential to be affected. The ED or designee will re-educate the AP/Payroll director on the requirements for new hire TB skin tests. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ¿ ED or designee will be responsible for auditing new employee files to ensure two step TB skin testing is completed. An audit of 5 employee files will be conducted monthly x 6 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by	09/22/2023

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	155815	A. BUILDING 00 B. WING	08/22/2023

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	facility on 5/16/23. CNA 10 began working at the facility on 7/26/23. The Maintenance Director began working at the facility on 5/15/23. The Tuberculin Testing For Employees forms for LPN 7, CNA 8, CNA 9, CNA 10, and the Maintenance Director were provided by the ED on 8/22/23 at 9:10 a.m. There was a 1st step TB test verification with result for each employee, but no 2nd step TB test or result for any of the 5 employees. An interview was conducted with the ED on 8/22/23 at 1:40 p.m. She indicated there was no 2nd step TB testing verification for LPN 7, CNA 8, CNA 9, CNA 10, and the Maintenance Director. As a policy, the facility followed state regulations for employee TB testing.		the ED. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. 5. Date of completion: 09/22/23	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00413214. Complaint IN00413214- No deficiencies related to the allegations are cited. Survey dates: August 16, 17, 18, 21, and 22, 2023.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond	

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	Facility number: 013019 Residential Census: 21 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 29, 2023		to the allegation of noncompliance cited during the Recertification and State Licensure Survey conducted on August 22, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of September 22, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to ensure annual and semi-annual weights were obtained for 1 of 5 residents records reviewed. (Resident 7) Findings include:	R 0216	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? • Resident 7 has discharged 2: How other residents having the	09/22/2023

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	The clinical record for Resident 7 was reviewed on 8/22/23 at 1:15 p.m. The diagnosis for Resident 7 included, but was not limited to, dementia. The resident was admitted to facility on 9/28/22. The residents clinical record did not include weights obtained. An interview was conducted with Nurse Consultant (NC) 2 on 8/22/23 at 4:00 p.m. She indicated she was unable to provide weights that were obtained for Resident 7. The weights policy was provided by the NC 2 on 8/22/23 at 4:25 p.m. It indicated "...Purpose to ensure residents are maintaining good nutrition to remain close to ideal body weight. Procedures....2. Residents will be weighed monthly unless clinical condition indicates otherwise...3. Weight shall be recorded in the electronic health record. a. Weight shall also be recorded on the evaluation and service plan form at admission and quarterly..."		potential to be affected by the same deficient practice will be identified and what corrective action will be taken. • All residents have the potential to be affected. DHS or designee will educate the nursing staff on Guidelines for Weights 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ¿ DHS or designee will be responsible for auditing residents to ensure weights are obtained monthly. An audit of 5 residents will be conducted Monthly times 3 months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if	

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			no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. 5. Date of completion: 09/22/23	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility	R 0217	1: What corrective action(s) will be	09/22/2023

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	failed to ensure service plans were signed and dated by the resident and/or resident's representative for 4 of 5 residents records reviewed. (Residents 6, 7, 11 and 17) Findings include: 1. The clinical record for Resident 6 was reviewed on 8/22/23 at 1:00 p.m. The diagnosis for Resident 6 included, but was not limited to, dementia. The resident's service plan dated 3/2/23 indicated the plan for services the resident was needing. The service plan did not include resident/representative signature. 2. The clinical record for Resident 7 was reviewed on 8/22/23 at 1:15 p.m. The diagnosis for Resident 7 included, but was not limited to, dementia. The resident's service plan dated 3/2/23 indicated the plan for services Resident 7 was needing. The service plan did not include resident/representative signature. 3. The clinical record for Resident 11 was reviewed on 8/22/23 at 1:30 p.m. The diagnosis for Resident 11 included, but was not limited to, fracture of right femur. The resident's service plan dated 2/25/23 indicated the plan for services the resident was needing. The service plan did not include resident/representative signature. 4. The clinical record for Resident 17 was reviewed on 8/22/23 at 1:40 p.m. The diagnosis for Resident 17 included, but was not limited to, dementia. The resident's service plan dated 3/3/23 indicated		accomplished for those residents found to have affected by the deficient practice? • Residents 6,7,11, and 17 have signed service plans. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. • All residents have the potential to be affected. DHS or designee will educate the nursing staff on Evaluation and Service Plan guidelines. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ¿ DHS or designee will be responsible for auditing residents to ensure service plans are signed per policy. An audit of 5 residents will be conducted weekly x 4 weeks than monthly times 2 months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent	

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	the plan for services the resident was needing. The service plan did not include resident/representative signature. An interview was conducted with Nurse Consultant (NC) 2 on 8/22/23 at 4:00 p.m. She indicated she was unable to provide service plans that had been signed by the resident and/or resident's representatives. A evaluation and service plan guidelines policy was provided by the Nurse Consultant (NC) 2 on 8/22/23 at 4:25 p.m. It indicated "...Purpose. to provide documentation of nursing and ancillary care needs to develop a service plan. To determine acuity level based on the amount of assistance provide with both activities of daily living (ADL) and nursing care...2. A service plan shall be identified and implemented in response to the resident's evaluation and in collaboration with the resident and/or responsible party. The Assisted Living Director or designee will discuss the services he/she requires..."		corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. 5. Date of completion: 09/22/23	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to ensure medications were administered as ordered for 1 of 5 residents records reviewed. (Resident 6) Findings include: The clinical record for Resident 6 was reviewed on 8/22/23 at 1:00 p.m. The diagnosis for Resident 6 included, but was not limited to, dementia.	R 0240	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? • Residents 6 had no ill effects related to the alleged deficient practice. 2: How other residents having the potential to be affected by the same deficient practice will be	09/22/2023

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	A physician order dated 3/2/23 indicated the resident was to receive 0.25 milligrams of lorazepam twice a day. A physician order dated 5/31/23 indicate the resident was to receive 120 milligrams of diltiazem daily. The August 2023 Medication Administration Record (MAR) indicated the following days the resident did not receive the lorazapam or diltiazem due to unavailable: 120 milligrams of diltiazem: 8/1/23, 8/2/23, 8/3/23, 8/4/23, 8/5/23, 8/6/23, 8/7/23, 8/8/23, 8/9/23, 8/10/23, 8/11/23, 8/12/23 and 8/13/23, 0.25 milligrams of lorazepam: 8/7/23 - evening dose, and 8/8/23 - day and evening dose An interview was conducted with Nurse Consultant (NC) 2 on 8/22/23 at 4:00 p.m. She indicated pharmacy had changed which caused the delay in receiving the diltiazem, and the missing dosages of lorzapam the resident's supply had run out prior to ordering.		identified and what corrective action will be taken. • All residents have the potential to be affected. DHS or designee will educate the nursing staff on Assisted Living Medication Administration Guidelines. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? ¿ DHS or designee will be responsible for auditing medication administration history to ensure medications are given as ordered. An audit of 5 residents will be conducted weekly x 4 weeks than monthly times 2 months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? ¿ For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no	

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			concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. 5. Date of completion: 09/22/23	
R 0357 Bldg. 00	410 IAC 16.2-5-8.1(j)(1-3) Clinical Records - Noncompliance (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on interview and record review, the facility failed to ensure a resident's clinical record included notification of the physician and disposition of personal possessions and medications for 1 of 1 resident reviewed for death. (Resident 22) Findings include: The clinical record for Resident 22 was reviewed on 8/22/23 at 3:00 p.m. She was admitted to the facility on 4/12/23 and passed away in the facility on 6/21/23. The 6/21/23, 11:35 a.m. nurse's progress note read, "Staff notified this nurse that resident was sitting in chair and was not responsive. Resident had no pulse and had expired. Resident is a DNR [Do Not Resuscitate.] Family was notified." The 6/21/23 burial transit permit indicated her	R 0357	1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? • Residents 22's personal belongings were returned to the family. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. • All residents have the potential to be affected. DHS or designee will educate the nursing staff on the documentation requirements for a resident death. 3: What measures will be put into place or what systemic changes	09/22/2023

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	body was removed from the facility. There was nothing in the clinical record indicating physician notification of her death or disposition of Resident 22's personal possessions and medications. An interview was conducted with NC (Nurse Consultant) 2 on 8/22/23 at 4:32 p.m. She indicated the progress note only talked about family notification, not physician notification. She was able to locate an inventory sheet that said what Resident 22 came into the facility with, but nothing about disposition of her belongings.		will be made to ensure that the deficient practice does not recur? ¿ DHS or designee will be responsible for auditing resident charts to ensure required documentation in place after a death. An audit of 5 residents will be conducted weekly x 4 weeks than monthly times 2 months. The results of these audits will be reviewed by the QAPI committee overseen by the ED. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. 5. Date of completion: 09/22/23	