STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	10/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00360093, IN00362656, and IN00363446. Complaint IN00360093 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F684 and F759. Complaint IN00362656 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00363446 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684 and F759. Survey dates: September 27, 28, 29, 30, and October 1 and 4, 2021 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 5 Medicaid: 69 Other: 8 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	The Plan of Correction is the center's credible allegation of compliance. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. The facility respectfully requests a desk review for this plan of correction.	

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

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

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	Quality review completed on 10/7/21.			
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident			

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	representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on interview and record review, the facility failed to address resident council concerns in a timely manner. This had the potential to affect 10 residents who regularly attended the resident council meetings. Finding includes: During an interview with resident council members on 9/30/21 at 2:00 p.m., the residents indicated their concerns were not being addressed by facility management. They indicated there was no follow up or resolution to a list of ongoing concerns they had since May 2021. The concerns included, but were not limited to, resident alcohol use in the facility, staff respecting their rights and customer service. The Resident Council Meeting Minutes, dated June 24, 2021, indicated the Executive Director and Director of Nursing discussed concerns for follow up. The Resident Council Meeting Minutes, dated 8/5/21, indicated concerns were currently being worked on by the Executive Director and Director of Nursing. There was no indication the concerns had been resolved or were still being addressed. Interview with Social Service Designee, who served as the facility's Grievance Officer, on 9/30/21 at 3:35 p.m., indicated there had been no grievances logged for the resident council in the past four months.	F 0565	1. 1. The facility will ensure that resident concerns are addressed in a timely manner. No residents were harmed. 2. 2. All residents will be interviewed for any concerns. Any findings will be addressed by facility management and placed on a grievance form for follow up and resolution. 3. 3. All department heads will be in-serviced on following up with resident council concerns in a timely manner. 4. 4. The ED or designee will attend resident council monthly x 3 months to ensure residents' concerns are being placed on a grievance form and addressed in a timely manner. The ED will report to the QAPI Committee monthly findings from the monthly audits. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required.	11/08/2021

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	Interview with the Activity Director, on 9/30/21 at 4:14 p.m., indicated she would make a copy of the Resident Council Meeting Minutes and give to the appropriate department for action. She indicated the concerns had not been written as official grievances, and weren't being acted upon. 3.1-3(l)			
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:			

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	(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of			

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	resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.			
	Based on observation, record review, and interview, the facility failed to initiate and investigate grievances that were reported to staff for 2 of 2 residents reviewed for grievances. (Residents 54 and J) Findings include: 1. Resident 54's record was reviewed on 9/29/21 at 2:05 p.m. The Quarterly Minimum Data Set assessment, dated 8/27/21, indicated the resident	F 0585	1. 1. Resident 54 met with the DON and ED regarding her concern with care. Resident #54 was not harmed. Resident J remains anonymous as part of the complaint survey process. 2. 2. All residents will be interviewed for any concerns. Any findings will be addressed by facility management and placed on a grievance form for follow up	11/08/2021

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	was cognitively intact. Diagnoses included, but were not limited to, status post ankle fracture, Diabetes Mellitus, and obesity. Interview with the resident on 9/27/21 at 9:34 a.m., indicated another resident had made degrading comments to her the previous Friday, 9/24/21. The resident indicated she told the Social Service Director about the event, and was told she couldn't file a grievance against another resident. Interview with the Social Service Designee on 9/30/21 at 11:05 a.m., indicated the Social Service Director was not available, but she knew there was not a grievance made regarding Resident 54 and the other resident. She indicated she would speak with the resident about her concern at that time. 2. On 9/28/21 at 8:46 a.m., Resident J was observed in her bed. She had an incision from her right groin to her ankle. The dressing to the uppermost part of the incision, near her groin, was off. At 10:10 a.m., the Wound Nurse was observed changing the resident's dressings. She indicated to the resident she had reported the night nurse had refused to replace the missing dressing. The resident's record was reviewed on 9/29/21 at 10:03 a.m. The resident was admitted on 9/21/21 status post right leg surgery due to arteriosclerosis of native arteries. A Physician's order, dated 9/22/21, indicated the incision was to be cleansed daily with normal saline and covered with a dry dressing. Interview with the resident on 9/28/21 at 8:46 a.m.,		and resolution. 3. 3. All staff will be in-serviced on the Grievance Policy. 4. 4. ED or designee will audit grievance logs weekly x 90 days to validate the grievances have been initiated and investigated timely. The ED will report to the QAPI Committee monthly findings from the monthly audits. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required.	

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	indicated she had asked the night nurse to replace the dressing that had come off. The nurse had refused and indicated she had to wait for the Wound Nurse. The resident was upset and tearful, and was afraid the wound would become infected. Interview with the Wound Nurse, on 9/30/21 at 1:35 p.m., indicated she had reported the night nurse refusal to replace the dressing, but could not remember who she reported it to. Interview with the Director of Nursing, on 9/30/21 at 1:40 p.m., indicated she was not aware of the resident's grievance regarding the night nurse. Interview with the Executive Director, on 9/30/21 at 1:50 p.m., indicated he was not aware of the resident's grievance regarding the night nurse. During a follow up interview with the Wound Nurse on 9/30/21, she indicated she had been educated about the grievance process and had initiated a grievance for the resident. The current Grievance policy was provided by the Nurse Consultant on 9/30/21 at 11:59 a.m., indicated, "...The Facility recognizes that residents have the right to voice grievances to the facility...Such grievances include those with respect to care and treatment that has been furnished, the behavior of staff and other residents and any other concern regarding the resident's stay...." 3.1-7(a)(2)			
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans			

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	§483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on record review and interview, the facility failed to ensure the residents were involved in making decisions about their care related to the timeliness of care plan conferences and medication changes for 4 of 5 residents reviewed for participation in care planning. (Residents B, 80, 81, and G) Findings include: 1. During an interview with Resident B on 9/28/21 at 9:37 a.m., the resident indicated the facility had	F 0657	1. 1. Resident B, #80, #81, and G were not harmed. 2. 2. All residents/responsible parties will be given information regarding date and time of their next care conference and given the opportunity to participation in their next scheduled care conference. 3. 3. All department heads will be in-serviced on the care plan meeting process with emphasis	11/08/2021

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	sent a letter to him for a care conference for 9/23/21, but they never held it. His mother even came to the facility for the conference. The record for Resident B was reviewed on 9/29/21 at 12:29 p.m. The resident was admitted to the facility on 4/28/21. Diagnoses included, but were not limited to, respiratory failure, morbid obesity, bipolar disorder, depressive disorder, schizophrenia, pulmonary embolism, anemia, high blood pressure, anxiety, chronic pain syndrome, weakness, and peripheral neuropathy. The Quarterly Minimum Data Set (MDS) assessment, dated 8/23/21, indicated the resident was moderately impaired for decision making and needed extensive assist with a 2 person physical assist for bed mobility, transfers, and toilet use. The resident needed extensive assist with a 1 person physical assist for personal hygiene. There was no documentation the resident had a care plan conference since admission. Interview with the Social Service Designee on 9/30/21 at 11:00 a.m., indicated the resident had a care conference set up for 9/23/21 but it did not happen. 2. Interview with Resident 80 on 9/27/21 at 3:43 p.m., indicated the resident had not been invited or attended a care plan conference. The record for Resident 80 was reviewed on 9/29/21 at 8:51 a.m. Diagnoses included, but were not limited to , copd, morbid obesity, stroke, Parkinson's disease, congestive heart failure, major depressive disorder, chronic kidney disease, and poly osteoarthritis.		on residents given on the opportunity to participate in decision making and having care conferences. All licensed nurses will be in-serviced on notifying resident/responsible party with changes to their medication regimen. 4. 4. The DON or designee will audit weekly x 90 days care plan meetings for the week to validate the resident and resident representative were able to be involved in making decisions about their care and documentation implemented. The DON or designee will audit weekly x 90 days any residents with a medication change to validate the resident/responsible party were made aware of the change. The ED/DON will report to the QAPI Committee monthly findings from the monthly audits. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required.	

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The Annual Minimum Data Set (MDS) assessment, dated 9/15/21 indicated the resident was moderately impaired for decision making.

There was no documentation if or when the resident had a care conference in the last year.

Interview with the Social Service Designee on 9/30/21 at 11:00 a.m., indicated the resident had a care conference set up for 9/16/21 but it did not happen.

3. Interview with Resident 81 on 9/27/21 at 3:31 p.m., indicated the resident had not been invited or attended a care plan conference.

The record for Resident 81 was reviewed on 9/30/21 at 12:25 p.m. Diagnoses included, but were not limited to, fibromyalgia, copd, fracture of tibia and right shoulder, type 2 diabetes, history of falling, anxiety, and shortness of breath.

A Significant Change Minimum Data Set (MDS) assessment, dated 9/16/21, indicated the resident was moderately impaired for decision making. The resident was an extensive assist with a 1 person physical assist for bed mobility and transfers. The resident had a fall with a major injury since prior assessment.

The last care conference documented in the record was on 9/9/20. There was no documentation of a current care plan conference.

Interview with the Social Service Designee on 9/30/21 at 11:00 a.m., indicated the resident has not had a care conference.4. Interview with Resident G on 9/27/21 at 11:17 a.m. indicated she had received a new medication starting on 9/25/21. She had looked up the pill on the internet and

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	determined it was Claritin (loratadine, an antihistamine medication). She usually received Benadryl (diphenhydramine, an antihistamine medication) and was confused as to why the medication had been switched. She had not been notified of the change by any staff or her Physician. Record review for Resident G was completed on 9/29/21 at 1: 27 p.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, and bipolar disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/13/21, indicated the resident was cognitively intact. The Physician's Order Summary, dated 9/2021, indicated an order for Benadryl 25 mg (milligrams) two times a day had been discontinued on 9/24/21 and an order for Claritin 10 mg every morning had been started on 9/25/21. The Progress Notes, dated 9/23/21 through 9/26/21, lacked documentation the resident had been notified of the medication changes. Interview with the Nurse Consultant on 9/29/21 at 3:33 p.m., indicated the medication orders had been changed based on a pharmacy recommendation. The resident should have been notified of the changes. 3.1-35(d)(2)(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			

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	nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to ensure dependent residents received assistance with ADL's (activities of daily living) related to nail and oral care for 3 of 7 residents reviewed for ADL's. (Residents F, E, and B) Findings include: 1. On 9/27/21 at 12:33 p.m., Resident F was observed in his room in bed. The resident had multiple areas of discoloration to his left and right forearms. There was a dressing in place to the left forearm. There was a dark substance observed underneath the resident's fingernails. On 9/28/21 at 2:20 p.m., the dark substance remained underneath the resident's fingernails. On 9/30/21 at 2:08 p.m., the dark substance remained underneath the resident's fingernails. The record for Resident F was reviewed on 9/29/21 at 10:08 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, mood disorder, ventricular fibrillation, thrombocytopenia (low platelet levels in the blood), and anemia. The Quarterly Minimum Data Set (MDS) assessment, dated 7/26/21, indicated the resident was cognitively impaired for daily decision making and required extensive one person assistance for personal hygiene. The Care Plan, dated 4/9/21, indicated the resident had an ADL self care performance deficit and required assistance with ADL's related to a	F 0677	1. 1.Resident F had nail care provided. Resident E had nail care and his nails cut. Resident B had his teeth brushed. No residents were harmed. 2. 2.An audit of all dependent residents was completed to validate care is provided for nails and oral care. Any findings will be addressed immediately. 3. 3. All nursing staff will be educated on providing ADL care to dependent resident with emphasis on nail and oral care. 4. 4. The DON or Designee will audit weekly x 90 days, five dependent residents to validate assistance with ADL care is being provided with emphasis on nail and oral care. The DON will report to the QAPI Committee monthly findings from the monthly audits. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required.	11/08/2021

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cognitive deficit, his disease process, functional deficit, and incontinence. Interventions included, but were not limited to, identify tasks, events that caused frustration, and provide assistance as needed.

Interview with the West Unit Manager on 9/30/21 at 2:15 p.m., indicated she would have someone clean the resident's fingernails.

2. On 9/27/21 at 10:55 a.m., Resident E was observed in his room in bed. The fingernails on both hands were long and a brown substance was observed underneath some of his nails.

Interview with the resident at that time, indicated he did not like his fingernails long and he would like them cut.

On 9/28/21 at 10:02 a.m. and 2:20 p.m., the resident's fingernails remained long with a dark substance underneath.

On 9/29/21 at 9:52 a.m., 11:22 a.m., and 1:38 p.m., the resident's fingernails remained long with a dark substance underneath.

On 9/30/21 at 2:15 p.m., the resident's fingernails remained long with a dark substance underneath.

The record for Resident E was reviewed on 9/28/21 at 2:31 p.m. Diagnoses included, but were not limited to, cerebral palsy, recurrent depressive disorder, muscle weakness, and lack of coordination.

The Quarterly Minimum Data Set (MDS) assessment, dated 8/7/21, indicated the resident was moderately impaired for daily decision making and required extensive one person assistance with

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personal hygiene.

The Care Plan, dated 6/9/21, indicated the resident had an ADL self care performance deficit. He required assistance with ADL's due to his disease process, functional deficit, incontinence, cerebral palsy, cognitive status, and contractures. Interventions included, but were not limited to, identify tasks, events that caused frustration, and provide assistance as needed.

Interview with the West Unit Manager on 9/30/21 at 2:15 p.m., indicated she would ask one of the CNAs to trim the resident's fingernails. 3. Interview with Resident B on 9/28/21 at 9:41 a.m., indicated the CNAs do not offer to brush the resident's teeth and he did not remember how long its been since they have been brushed.

On 9/29/21 at 9:50 a.m., the resident was observed in bed. At that time, CNA 5 and CNA 3 were going to provide a.m. care for the resident. CNA 3 gathered the supplies for the bath and CNA 5 washed the resident. After the bath was complete, both CNAs packed up the dirty laundry and trash, removed their gloves and performed hand hygiene and left the room. At no time did either CNA ask the resident if he wanted his teeth brushed. The resident was not offered, therefore his teeth did not get brushed.

Interview with CNA 5 and CNA 3 on 9/29/21 at 10:25 a.m., indicated neither one of them offered oral care for the resident. Oral care was part of a.m. and p.m. care.

The record for Resident B was reviewed on 9/29/21 at 12:29 p.m. The resident was admitted to the facility on 4/28/21. Diagnoses included, but were not limited to, respiratory failure, morbid

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	obesity, bipolar disorder, depressive disorder, schizophrenia, pulmonary embolism, anemia, high blood pressure, anxiety, chronic pain syndrome, weakness, and peripheral neuropathy. The Quarterly Minimum Data Set (MDS) assessment, dated 8/23/21, indicated the resident was moderately impaired for decision making and needed extensive assist with a 2 person physical assist for bed mobility, transfers, and toilet use. The resident needed extensive assist with a 1 person physical assist for personal hygiene. A Care Plan, revised on 4/30/21, indicated the resident had a ADL (Activities of Daily Living) deficit related to morbid obesity, schizophrenia, bipolar, depression, anxiety, weakness, and decline in functional status. Interview with the West Unit Manager on 9/30/21 at 11:00 a.m., indicated the CNAs were to offer oral care with a.m. care and p.m. care. This Federal tag relates to Complaints IN00360093 and IN00362656. 3.1-38(a)(3)(C) 3.1-38(a)(3)(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan,			

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	and the residents' choices. Based on observation, record review and interview, the facility failed to ensure a doppler ultrasound (diagnostic test) was completed in a timely manner for 1 of 1 residents reviewed for a change of condition (Resident J), and medications were given on time for 2 of 6 residents reviewed for medication administration. (Residents D and G) Findings include: 1. The record for Resident J was reviewed on 9/29/21 at 10:03 a.m. The resident was admitted on 9/21/21 status post right leg surgery due to arteriosclerosis of native arteries. The resident refused the cognitive assessment. A Nurses' Note, dated 9/24/21 at 1:16 p.m., indicated the resident had weak pedal pulses in her right leg. The Physician had been notified and orders were received for an arterial doppler of the right leg (an ultrasound used to assess veins and arteries). A call was placed to the X-ray service to schedule the procedure. A Physician's Order, dated 9/27/21, indicated the resident was to have a venous doppler to the right leg. Interview with RN 1, on 9/28/21 at 10:30 a.m., indicated the order had been changed from an arterial doppler to a venous doppler. She indicated the X-ray service had not been out to perform the procedure yet. Interview with the Director of Nursing, on 9/29/21 at 3:27 p.m., indicated the normal time for the X-ray service was within 48 hours, and they had not been out yet. She indicated the X-ray service	F 0684	1. 1. Resident J was not harmed and the Doppler has been obtained. Resident D was not harmed and physician was notified of late medication administration. Resident G was not harmed and physician was notified of late medication administration. 2. 2. An audit of all residents diagnostic orders will be completed to validate diagnostic orders were completed. Any findings will be notified to the resident/resident representative and physician. 3. 3. All licensed nurses will be in-serviced on following physician orders with emphasis on competing diagnostic testing in a timely manner and medication administration. 4. 4. The DON or Designee will audit weekly x 90 days all diagnostic testing for the week to validate diagnostic testing was ordered and completed in a timely manner. The DON will report to the QAPI Committee monthly findings from the weekly audits. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required.	11/08/2021

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	had indicated the technician was on the way on 9/24/21, and she was unsure why the test had not been completed. Interview with the East Unit Manager, on 9/30/21 at 1:30 p.m., indicated the X-ray service had come that morning at 10:52 a.m. and completed an arterial and venous ultrasound. This was six days after the initial Physician's Order for the doppler. 2. Interview with Resident D on 9/28/21 at 10:13 a.m., indicated she had received all of her medications late on 9/25/21 and 9/26/21. One of her medications, Renvela (a phosphate binder, dialysis medication), was supposed to be taken with meals and she had not received it until long after she had eaten. The record for Resident D was reviewed on 9/28/21 at 2:37 p.m. Diagnoses included, but were not limited to, congestive heart failure, chronic kidney disease, and hypertension. The Quarterly Minimum Data Set assessment, dated 9/21/21, indicated the resident was cognitively intact. The Physician's Order Summary, dated 9/2021, indicated an order for sevelamer (Renvela) 800 mg (milligrams) 3 tablets with meals at 0800, 1200, and 1700. The Medication Administration Record (MAR), dated 9/2021, indicated the resident received her medications late on the following dates and times: - 9/25/21: The 0800 and 0900 scheduled medications were administered from 1022-1025. The 1200 scheduled medication was administered at 1328. The 1700 and 2000 scheduled medications were administered at 2150.			

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- 9/26/21: The 0800 sliding scale insulin was administered at 1050. The 1700 and 2000 scheduled medications were administered at 2202.

Interview with the Nurse Consultant on 9/29/21 at 11:12 a.m., indicated the medications had been given late on 9/25/21 and 9/26/21.

3. Interview with Resident G on 9/27/21 at 11:17 a.m., indicated she had received her morning medications over four hours late on 9/1/21.

Record review for Resident G was completed on 9/29/21 at 1: 27 p.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, and bipolar disorder.

The Quarterly Minimum Data Set (MDS) assessment, dated 9/13/21, indicated the resident was cognitively intact.

The Medication Administration Record (MAR), dated 9/2021, indicated the Resident's 9/1/21 0800 scheduled medications were administered at 1316.

Interview with the Nurse Consultant on 9/29/21 at 11:12 a.m., indicated the medications had been given late on 9/1/21.

A current facility policy, titled "Medication Administration," indicated, "...1...f. Observe the five rights in giving each medication:...ii. right time...ff. Medications will be administered within the time frame of one hour before up to one hour after time ordered. i. For medication to be taken around meals: 1. Before meals: Provide medications 30 minutes before meal time. 2. After meals: provide medications 30 minutes after meal time..."

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	This Federal tag relates to Complaints IN00360093 and IN00363446. 3.1-37(a)			
F 0687 SS=D Bldg. 00	483.25(b)(2)(i)(ii) Foot Care §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. Based on observation, record review and interview, the facility failed to ensure dependent residents received foot care and had routine visits with a podiatrist related to long and thick toenails for 1 of 7 residents reviewed for ADL's. (Resident B) Finding includes: During an interview with Resident B on 9/28/21 at 9:41 a.m., indicated his toenails have not been cut in a long time and they were very long. On 9/29/21 at 9:50 a.m., the resident was observed in bed. At that time, CNA 5 and CNA 3 were going to provide a.m. care for the resident. CNA 3 gathered the supplies for the bath and CNA 5 washed the resident. CNA 3 removed the resident's socks so his feet could be observed.	F 0687	1. 1. Resident B was placed on the podiatrist list for nail care to include trimming. 2. 2. All residents toe nails will be assessed and follow-up care to a podiatrist will be scheduled as needed or nails trimmed. 3. 3. All nursing staff and IDT will be educated on providing nail care to dependent residents and scheduling a podiatrist visit for toenail care. 4. 4. The DON or Designee will audit weekly x 90 days five dependent residents to validate assistance with ADL care is being provided with emphasis on toenail. The DON will audit monthly the podiatrist visits have been	11/08/2021

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	His toenails were very long on both feet. The record for Resident B was reviewed on 9/29/21 at 12:29 p.m. The resident was admitted to the facility on 4/28/21. Diagnoses included, but were not limited to, respiratory failure, morbid obesity, bipolar disorder, depressive disorder, schizophrenia, pulmonary embolism, anemia, high blood pressure, anxiety, chronic pain syndrome, weakness, and peripheral neuropathy. The Quarterly Minimum Data Set (MDS) assessment, dated 8/23/21, indicated the resident was moderately impaired for decision making and needed extensive assist with a 2 person physical assist for bed mobility, transfers, and toilet use. The resident needed extensive assist with a 1 person physical assist for personal hygiene. A Care Plan, revised on 4/30/21, indicated the resident had a ADL (Activities of Daily Living) deficit related to morbid obesity, schizophrenia, bipolar, depression, anxiety, weakness, and decline in functional status. Interview with the West Unit Manager on 10/1/21 at 10:10 a.m., indicated she was unaware the resident's toenails were long and in need of trimming. 3.1-47(a)(7)		completed for 90 days. The DON will report to the QAPI Committee monthly findings from the weekly audits. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required.	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates			

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	that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.			
	Based on observation, record review and interview, the facility failed to ensure a resident with a contracture (permanent shortening of a muscle or joint resulting in decreased movement) received the necessary treatment and services to prevent further decline for 1 of 3 residents reviewed for limited range of motion (ROM). (Resident 8) Finding includes: On 9/27/21 at 11:05 a.m., Resident 8 was observed in bed. At that time, both of her hands were closed and her fingers were contracted. There was no anticontracture device in either hand. On 9/28/21 at 10:00 a.m., and 3:00 p.m., the resident was observed in bed. At those times, both of her hands were closed and her fingers were contracted. There was no anticontracture device in either hand. On 9/29/21 at 8:30 a.m., and 10:25 a.m., the resident was observed in bed. At those times, both of her hands were closed and her fingers were contracted. There was no anticontracture device	F 0688	1. Resident #8 has an order for therapy evaluation for evaluation of splinting devices. 2. All residents with a contracture will be screened by therapy to validate necessary treatment and services are being provided to prevent further decline. Physician and family will be notified of any findings. 3. All nursing staff will be educated on residents with contractures and application of splinting devices per MD order, to ensure nursing is providing necessary treatment and services to prevent further decline. 4. The DON or Designee will audit weekly x 90 days five residents with contractures to validate necessary treatments and services are being provided to prevent further decline. The DON will report to the QAPI Committee monthly findings from the weekly audits. The QAPI committee will	11/08/2021

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	in either hand. On 9/29/21 at 1:05 p.m., the resident was observed sitting up in a wheelchair by the nurses' station. At that time, there was no splint in either hand. On 9/30/21 at 9:10 a.m., the resident was observed in bed. At that time, both of her hands were closed and her fingers were contracted. There was no anticontracture device in either hand. On 9/30/21 at 10:25 a.m., the resident was observed up in a wheelchair in her room. There were no anticontracture devices in her hands. The Restorative CNA was in the room and indicated she had not been placing the bilateral hand splints on the resident due to her scratches on her forearms. She indicated she worked the floor as a regular CNA Monday and Tuesday and Wednesday was her first time as the Restorative CNA. She reported to the Rehab Director that she was not donning the hand splints due to the areas on the forearms, however, no other device was placed in the resident's hands to prevent further decline. The record for Resident 8 was reviewed on 9/30/21 at 9:45 a.m.. Diagnoses included but were not limited to, cardiomyopathy, heart failure, high blood pressure, chronic kidney disease, stroke, atrial fibrillation, protein calorie malnutrition, depressive disorder, anemia, and long term use of anticoagulants. The Significant Change Minimum Data Set (MDS) assessment, dated 6/29/21, indicated the resident was moderately impaired for decision making. The resident had impairment in range of motion to both sides of her upper and lower extremities.		determine when 100% compliance is achieved and if further monitoring is required.	

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A Care Plan, revised on 4/19/21, indicated the resident had alteration in musculoskeletal status related to contractures. The approaches were to provide passive range of motion with bilateral splint application to upper extremities.

Physician's Orders, dated 9/4/20, indicated after passive range of motion exercises perform hand hygiene with soap and water then apply right upper extremity functional hand splint, on in a.m. and off in p.m., up to 7 days a week. Observe skin under splint in a.m. and p.m. Report any abnormal findings to floor nurse.

Nurses' Notes, dated 9/29/21 at 10:24 a.m., indicated the resident was not wearing splints due to skin issues for 9/28 and 9/29/21. The entry was documented by Restorative CNA 1.

A Restorative Note, dated 9/27/21 at 3:15 p.m., indicated the resident was participating in the passive range of motion exercises and bilateral upper extremity functional hand splinting programs five to seven days a week.

Interview with the Director of Rehab on 9/30/21 at 10:35 a.m., indicated she was oversight with the restorative program and the MDS Coordinator does all of the documentation in the resident's clinical record. She indicated the restorative aides report to her if there were any problems. The Director of Rehab indicated she was going to pick the resident back up for therapy for a different type of positioning device as well as look at her splint situation as she does use some of her fingers to do things and the splints she has now, prevents her from doing anything with her fingers. The resident should have had something else in her hands to prevent further decline.

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	3.1-42(a)(2)			
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, record review, and interview, the facility failed to ensure a resident with a history of elopement was provided constant supervision and smoking risk assessments were completed for 1 of 1 residents reviewed for supervision (Resident 62) and 1 of 1 residents reviewed for smoking (Resident 81). Findings include: 1. On 9/27/21 at 10:40 a.m., Resident 62 was observed pushing his wheelchair towards the South Unit exit door to the courtyard to smoke. The resident pressed on the door until it released and let him out. An alarm sounded but no staff came around to observe what was happening. The Social Service Director had an office right across from the exit door, however, her door was closed. The resident was wearing a pair of shoes, shorts, t shirt and a robe. A wanderguard bracelet was observed around his right ankle. The resident sat down in his wheelchair and smoked a couple of cigarettes and when he was through, he stood up and walked towards the door and pulled on the handle until it opened. An alarm was sounding off and again no staff were around.	F 0689	1. 1. Resident #62 no longer resides at the facility. Resident #81 has a smoking assessment and wander assessment completed. 2. 2. All residents wishing to smoke will have updated smoking assessments completed. All residents that smoke will have a wander assessment completed. Residents needing supervision will be placed on scheduled smoke times so that supervision can be implemented. Secure Care moved the annunciator panel for the south hall doors moved to the West Wing. 3. 3. All staff education and will be completed on scheduled smoke times and supervised smokers to include responding to alarms. 4. 4.The DON or Designee will audit weekly x 90 days supervised smoking schedules to validate that all supervised smokers are	11/08/2021

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	There were other residents seated out on the patio and smoking as well. On 9/27/21 at 1:25 p.m., the resident was observed outside smoking and seated in his wheelchair. He was observed with a wanderguard bracelet on his right ankle. When he finished his cigarettes, he walked over to the door and pulled on the door handle until it came open. An alarm sounded as he pulled on the door. There were no staff outside with the resident. The Social Service director was observed in her office with the door open and observed the resident enter the facility. On 9/28/21 at 9:08 a.m. the resident was observed going out to the courtyard to smoke. There was no staff with him while he sat in his wheelchair to smoke his cigarettes. When he was ready to leave, he pulled on the handle until the door opened. An alarm sounded and he exited the courtyard and into the facility. On 9/28/21 at 1:50 p.m., the resident was observed walking out of the facility and into the courtyard to smoke. After he was finished, another resident opened the door for him and he left. There were no staff with him during the smoking time. The South Unit was closed at the present time in the facility. There were a couple of managerial offices down by the nurses' station, however, there were no residents in any rooms and the nurses' station was not in use. There were 2 sets of double doors leading into the unit. The courtyard entrance was in between both sets of doors and all the residents had access to the unit, as those double doors were not locked. All of the residents who smoked knew the code to get in and out of the courtyard. All residents who smoked in the facility were identified as being		following supervised smoking schedules and assigned employee are with supervised smokers. The DON will report to the QAPI Committee monthly findings from the weekly audits. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required	

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independent smokers and needed no help. The courtyard was open from 7:00 a.m. until 9:00 p.m., for all those residents who smoked. All smoking was unsupervised.

Interview with the Administrator on 9/28/21 at 1:50 p.m., indicated he was aware the resident had a history of elopement, however, he was unsure what his plan was regarding his supervision during smoke times and on the South Unit.

On 9/28/21 at 2:20 p.m., both of the South Unit exit doors were observed. Interview with the Maintenance Director indicated the door to the right had the wanderguard system, however, the door to the left did not have the wanderguard system and could simply be pushed and after 15 seconds would automatically open and anyone could leave the facility. At that time, the Maintenance Director pushed on the South Unit exit door until it automatically released after 15 seconds. The alarm could only be heard at the South Nurses' station and nowhere else. The alarm did not sound on the occupied West or East units.

Interview with the Maintenance Director at that time, indicated the alarm only sounded at the South Nurses' station and nowhere else. The unit had been closed for quite a while.

The record for Resident 62 was reviewed on 9/29/21 at 2:08 p.m. The resident was admitted to the facility on 7/9/21. Diagnoses included, but were not limited to, Parkinson's disease, bipolar disorder, schizophrenia, insomnia, altered mental status, high blood pressure, panic disorder, history of falling, and, muscle weakness.

The Quarterly Minimum Data Set (MDS)

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assessment, dated 9/2/21, indicated the resident was alert and oriented. The resident needed supervision with walking for locomotion on and off the unit.

There was no Care Plan for supervision.

Nurses' Notes, dated 7/14/21 at 9:30 a.m., indicated the resident signed out in sign out book this morning. The physician was made aware. At 3:45 p.m., the resident had not returned back to the facility. The resident's family was notified as well as the supervisor and Director of Nursing (DON)

Nurses' Notes, dated 7/17/21 at 7:29 p.m., indicated the resident arrived back to the facility via stretcher and was placed on 1 to 1 precautions.

Social Service Note, dated 7/19/21 at 1:21 p.m., indicated "writer met with resident this morning in the gazebo area. resident was in a pleasant mood. Writer asked what happened over the weekend and resident stated 'I just felt like I was locked up and needed to leave.' Writer asked resident what he plans to do next and resident responded 'I need to make a stop back at my condo in Merrillville; after that I plan to go to Hawaii to coach football and teach history,' resident expressed how much he enjoys children and that he used to be a very good football player. Resident continues to have delusional behavior and thoughts. Writer then met with resident brother and DON and discussed the possibility of elopement and residents safety. Residents brother/guardian requested safety measures such as wanderguard bracelet. Writer let brother know we could initiate that immediately. care plan has been put into place and wanderguard bracelets have been applied to residents right ankle and to his walker. SS to

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remain available as needed." (sic)

Physician's Orders, dated 7/19/21, indicated check wanderguard placement to right ankle every shift and maintain close supervision each shift per staff.

Interview with the Social Service Director (SSD) on 9/28/21 at 2:10 p.m., indicated they had a meeting with the family regarding his continued stay at the facility. The family did not want the resident to be transferred out but wanted a wanderguard bracelet on his ankle. They did not want him on a locked unit at another facility. She had given the resident the code to the smoking door several times so he could get in and out. The SSD further indicated she usually left the building around 4:30 p.m. during the week and no one else was on the unit working in the evenings or weekends to hear the door alarm.

Interview with the DON on 9/28/21 at 1:55 p.m., indicated the resident promised he would not leave again and a wanderguard bracelet was placed around his ankle. The South Unit had been vacant for quite awhile and she was not aware that only 1 of the 2 exit doors by the nurses' station had the wanderguard system. The resident was supposed to be on constant supervision at all times.

Interview with the Administrator on 9/28/21 at 3:00 p.m., indicated they were calling out the alarm company this evening and both exit doors on the South Unit will alarm at the occupied West Unit nurses' station.

2. On 9/28/21 at 2:00 p.m., Resident 81 was observed sitting in his wheelchair. He was observed smoking in the South Unit courtyard.

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	He was able to light his own cigarettes and put them out safely. The record for Resident 81 was reviewed on 9/30/21 at 12:25 p.m. Diagnoses included, but were not limited to, fibromyalgia, copd, fracture of tibia and right shoulder, type 2 diabetes, history of falling, anxiety, and shortness of breath. The Significant Change Minimum Data Set (MDS) assessment, dated 9/16/21, indicated the resident was moderately impaired for decision making. The resident was an extensive assist with a 1 person physical assist for bed mobility and transfers. The resident had a fall with a major injury since prior assessment. The Care Plan, revised on 6/21/21, indicated the resident utilized nicotine products. The approaches were to complete a smoking evaluation. The last documented smoking evaluation was dated 5/21/21 which indicated the resident was able to smoke independently. There were no other smoking assessments completed. Interview with the Director of Nursing on 9/30/21 at 4:45 p.m., indicated smoking assessments were to completed on admission, quarterly and for any change. 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy			

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	tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed for residents who were nutritionally at risk for 1 of 1 residents reviewed for nutrition. (Resident F) Finding includes: The record for Resident F was reviewed on 9/29/21 at 10:08 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, mood disorder, ventricular fibrillation, thrombocytopenia (low platelet levels in the blood), and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 7/26/21, indicated the resident was cognitively impaired for daily decision making	F 0692	1. 1. Resident F remained anonymous as part of the complaint survey process. **2.** **2.** All residents are at risk for not having meal consumption documented. **3.** **3.** All nursing staff have been educated on recording meal consumption. **4.** **4.** The DON or Designee will audit three times a week x 90 days residents' meal consumption records for complete documentation. The DON will report to the QAPI Committee monthly findings from the weekly audits. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required	11/08/2021

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	and he required supervision with eating. The resident also had a significant weight loss during the assessment reference period. The Care Plan, dated 7/19/21, indicated the resident had a nutritional problem related to his disease process, impaired skin integrity, and varied meal intake. Interventions included, but were not limited to, monitor meal intake. The September 2021 Physician's Order Summary (POS), indicated the resident was on a functional maintenance program for eating. The resident was to be assisted with his meals. Guide the utensils as needed and encourage the resident to eat meals as tolerated. The resident was to be fed as needed. The September 2021 food consumption log, indicated there was no documentation of meal intake on 9/1, 9/3, 9/5, 9/9, 9/11, 9/18, and 9/27/21. Breakfast was not documented on 9/6, 9/7, 9/10, 9/13, 9/21, and 9/23/21. Lunch was not documented on 9/6, 9/7, 9/8, 9/10, 9/13, 9/23, and 9/26/21. Dinner was not documented on 9/4 and 9/19/21. Interview with the West Unit Manager on 10/1/21 at 12:15 p.m., indicated the food consumption log should have been completed for each meal. 3.1-46(a)(1)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who			

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	require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			
	Based on observation, record review, and interview, the facility failed to provide the necessary care and services for residents who received hemodialysis related to not assessing and monitoring the resident's dialysis access site for 1 of 1 residents reviewed for dialysis. (Resident D) Finding includes: Interview with Resident D on 9/28/21 at 10:13 a.m., indicated she went to dialysis on Monday, Wednesday, and Friday. She had a dialysis catheter to her right chest. The record for Resident D was reviewed on 9/28/21 at 2:37 p.m. Diagnoses included, but were not limited to, congestive heart failure, chronic kidney disease, and hypertension. The Quarterly Minimum Data Set assessment, dated 9/21/21, indicated the resident was cognitively intact and received dialysis. A current Care Plan, indicated the resident required hemodialysis and had a perma cath (dialysis access catheter) in place. The interventions included to monitor, document, and report any signs and symptoms of infection to the access site. The 9/2021 Treatment Administration Record (TAR) and Medication Administration Record (MAR) lacked any monitoring or assessment of the right chest catheter for any signs of infection	F 0698	1. 1. Resident D has assessing and monitoring of the dialysis site implemented. 2. 2. All residents with dialysis services will have orders to assess and monitor the site daily. Any findings will be reported to the physician and dialysis center. 3. All Licensed Nurses will be educated on dialysis site assessment, monitoring, and documentation daily. **4.** **4.** The DON or Designee will audit weekly x 90 days, residents who are on dialysis to validate orders for assessing, monitoring, and documentation are completed. The DON will report to the QAPI Committee monthly findings from the weekly audits. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required	11/08/2021

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	or bleeding. On the resident's dialysis days, a pre-dialysis evaluation and a post-dialysis evaluation were completed, which included monitoring of the catheter site. There was lack of documentation to indicate the access site was monitored on the resident's non-dialysis days. Interview with the Nurse Consultant on 9/29/21 at 1:41 p.m., indicated the dialysis access site should have been monitored daily. A current facility policy, titled "Hemodialysis Care and Monitoring," indicated, "VI Specific types of vascular access devices....c. Catheters...v...2. Monitor for signs/symptoms of infection..." 3.1-37(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse			

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	consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure medications were held per blood pressure parameters for 1 of 9 residents reviewed for unnecessary medications. (Resident 7) Finding includes: The record for Resident 7 was reviewed on 9/29/21 at 1:47 p.m. Diagnoses included, but were not limited to, stroke, depressive episodes, and hypertensive heart disease without heart failure. The September 2021 Physician's Order Summary (POS) indicated the resident was to receive Metoprolol Tartrate (a medication used to treat high blood pressure) 50 milligrams (mg) twice a day. The medication was to be held if the resident's blood pressure was below 100/50. The Physician was to be called if the resident's blood pressure was above 150/90. The resident was also receiving Lisinopril (a medication used to treat high blood pressure) 20 mg daily. The medication was to be held if the resident's blood pressure was below 100/50. The Physician was to be called if the resident's blood pressure was above 150/90. The August 2021 Medication Administration Record (MAR) indicated on 8/31/21 at 8:00 a.m., the resident's blood pressure was 92/66. The Metoprolol and Lisinopril were signed out as being given.	F 0757	1. 1. Resident # 7 was not harmed. Physician and family were notified of medication administration outside of set parameters. **2. 2.**An audit will be completed of all residents with BP medications that have set parameters to validate medications are being administered according to the physician's orders. The physician will be notified of any findings. **3. 3.** All Licensed Nurses will complete education Medication Administration and following physician's orders for parameters with medication administration. **4. 4.** The DON or Designee will audit weekly x 90 days residents who are on antihypertensive medication with orders to validate medications were administered per physician's orders that have parameters and are being followed. Any findings will be addressed immediately. The DON will report to the QAPI Committee monthly findings from the weekly audits. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required	11/08/2021

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	The September 2021 MAR indicated the resident's 8:00 a.m. blood pressure was below 100/50 on the following dates: - 9/19/21 98/68 - 9/25/21 96/67 - 9/26/21 96/67 The Metoprolol and Lisinopril were signed out as being given for the above dates. Interview with the Nurse Consultant on 10/1/21 at 10:00 a.m., indicated the medications should have been held if the systolic blood pressure (top number) was below 100 or the diastolic blood pressure (bottom number) was below 50. She also indicated a clarification order would be obtained. 3.1-48(a)(3)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used			

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	psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on observation, record review, and interview, the facility failed to ensure residents were free from unnecessary psychotropic medications related to conflicting psychotropic medication orders and psychiatry recommendations for 1 of 9 residents reviewed for unnecessary medications. (Resident 36)	F 0758	1. 1. Resident #36 has had Psychiatry services review her medications and clarify current regimen. Family has been notified and plan of care revised. **2. 2.** All residents receiving psychotropic medications will have an audit completed to validate	11/08/2021

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	Findings include: On 9/27/21 at 11:01 a.m., Resident 36 was observed lying in bed in her room. The resident was repetitively yelling out. She indicated she wanted to see her mom. On 9/28/21 at 9:33 a.m., the resident was observed sitting up in a geri chair in her room watching television. She was repetitively yelling out. Staff entered the room to provide care for the resident, she continued to yell out. The staff then assisted the resident to sit out near the Nurses' Station, where she continued to yell out. On 9/29/21 at 9:04 a.m., the resident was seated in a geri chair near the Nurses' Station. The resident was repetitively yelling out. Staff sat in a chair next to the resident and spoke with her, she continued to yell out. The record for Resident 36 was reviewed on 9/30/21 at 9:50 a.m. Diagnoses included, but were not limited to, schizoaffective disorder, anxiety disorder, borderline personality disorder, and bipolar disorder. The Admission Minimum Data Set assessment, dated 7/1/21, indicated the resident was cognitively impaired and received antipsychotic and anti-anxiety medications. A Psychiatry Services Progress Note, dated 8/23/21, indicated to continue haloperidol (Haldol, an antipsychotic medication) 20 mg (milligrams) 3 times a day, olanzapine (Zyprexa, an antipsychotic medication) 5 mg daily, Depakote (divalproex, a mood stabilizing medication) 250 mg daily and 500 mg at bedtime, and lorazepam (Ativan, an anti-anxiety medication) 2 mg 3 times a day.		current orders are accurate with psychiatry services and/or physicians' orders. The physician and family will be notified of any findings and the plan of care revised if necessary. **3.** **3.** Education will be provided to the IDT and psychiatry provider regarding validation of psychiatry notes and medication orders. **4.** **4.** The DON or Designee will audit weekly x 90 days five residents who are on psych service to validate all orders are correct and valid. Then monthly in the P&T committee meeting as part of an ongoing clinical process. The DON will report to the QAPI Committee monthly findings from the weekly audits. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required	

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A Psychiatry Services Progress Note, dated 9/21/21, indicated to continue haloperidol 10 mg 3 times a day, olanzapine 5 mg daily, Depakote 250 mg daily and 500 mg at bedtime, and to reduce lorazepam to 1 mg two times a day.

The Medication Administration Record (MAR), dated 9/2021, indicated the resident received the following medications:
- 9/1/21-9/22/21- Ativan 1 mg, 1 tablet, three times a day at 0600, 1400, and 2200.
- 9/3/21-9/22/21- Ativan 1 mg, 1 tablet, daily at 2000.
- 9/22/21-9/28/21- Ativan 2 mg, 2 tablets, two times a day at 0500 and 2000.
- 9/28/21-current- Ativan 2 mg, 1 tablet, two times a day at 0500 and 2000.
- 9/1/21-current- valproate sodium 250 mg/5 ml (milliliters), 5 ml two times a day at 0800 and 2000.
- 9/1/21-9/5/21- Depakote ER (extended release) 500 mg, 1 tablet, daily at 0800.
- 9/6/21-9/12/21- Depakote Sprinkles 125 mg, 4 capsules, daily at 0500.
- 9/13/21-9/24/21- Depakote Sprinkles 125 mg, 2 capsules, two times a day at 0500 and 2000.
- 9/1/21-current- haloperidol 10 mg, 1 tablet, three times a day at 0600, 1400, and 2200.

The resident had not received the olanzapine medication.

Interview with the Nurse Consultant on 10/1/21 at 9:11 a.m., indicated after reading the Psychiatry Services Progress Notes and reviewing the Physician's Orders she was unsure what medications the resident was supposed to be receiving. She had a call out to Psychiatry Services to clarify the medications, but they had not responded yet.

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	Interview with the Director of Nursing on 10/1/21 at 12:12 p.m., indicated she still had not received any response back from the Psychiatry Services provider. 3.1-48(a)(6)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 6 residents observed during medication administration. Two medication errors were observed during 25 opportunities for error in medication administration. This resulted in a medication error rate of 8%. (Resident H) Finding include: On 9/29/21 at 9:43 a.m., LPN 1 was observed preparing Resident H's medications, which included levothyroxine, aspirin, citalopram, dilitazem, Eliquis, famotidine, ferrous sulfate, furosemide, vitamin B 12, Miralax, and an Incruse Ellipta inhaler. LPN 1 then administered the medications and inhaler to the resident and indicated she was done administering all the resident's morning medications. The Physician's Order Summary, dated 9/2021, indicated the following orders: - Wixhela Inhub 100-50 mcg (micrograms) aerosol powder inhaler, 1 puff orally two times a day.	F 0759	1. 1. Resident H was not harmed. The physician was notified of the levothyroxine administered late on 09/29/2021. 2. 2. All residents have the potential to be affected. 3. 3. All licensed nurses and QMAs will be educated on medication administration to include the 5 rights of medication administration. 4. 4. The DON or Designee will observe medication administration for 5 residents weekly for 90 days to validate all medications are given within the allotted time frame. The DON will report to the QAPI Committee monthly findings from the weekly audits. The DON will audit medication administration three times a week to validate medications are administered timely. Any findings will be addressed immediately. The QAPI committee will	11/08/2021

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	- levothyroxine 75 mcg daily at 0700 Interview with LPN 1 on 9/29/21 at 10:05 a.m., indicated she was unsure why the levothyroxine medication was not given on the previous shift as scheduled. She had overlooked the order for the Wixhela inhaler and would administer it now. A current facility policy, titled "Medication Administration," indicated, "...1...f. Observe the five rights in giving each medication:...ii. right time...ff. Medications will be administered within the time frame of one hour before up to one hour after time ordered..." This Federal tag relates to Complaints IN00360093 and IN00363446. 3.1-48(c)(1)		determine when 100% compliance is achieved and if further monitoring is required	
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			

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	diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (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			

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	and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to hand hygiene not completed after glove removal and gloves being worn in the hall for 1 of 1 observations of morning care and 1 of 1 observations of wound care. (Residents 51 and B) Findings include: 1. During a random observation on 9/28/21 at 10:44 a.m., CNA 4 was observed in the center hall of the West Unit carrying a garbage bag in each hand. The CNA was wearing a glove on each hand. She entered the code to the soiled utility room with her gloved hand and entered the room. When she exited the soiled utility room, she was no longer wearing gloves. At 10:57 a.m., the CNA was again observed in the center hall of the unit carrying a bag of garbage in each hand. Again, she was wearing gloves while in the hallway. Interview with the Director of Nursing on 10/1/21 at 9:42 a.m., indicated gloves should not be worn	F 0880	**F 880** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** C.NA 4 was educated on doffing gloves before exiting room and performing hand hygiene. Wound nurse, C.NA 3 and 5 were educated on hand hygiene to be performed before donning and after doffing gloves **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice. The DON or designee will complete the following: - Ensure all staff involved are educated in infection control practices regarding resident	10/27/2021

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	in the hallway. 2. On 9/30/21 at 10:35 a.m., the Wound Nurse was observed gathering supplies to change Resident 51's dressings to his pressure ulcers. While standing in front of the treatment cart, the Wound Nurse used hand sanitizer and then donned an isolation gown. She then proceeded to get her supplies ready and then donned one glove. She did not use hand sanitizer prior to donning the glove at that time. The supplies were taken into the resident's room on a styrofoam tray and placed at the foot of the resident's bed on top of his sheets. The Wound Nurse proceeded to remove the dressings to the resident's sacrum, right hip and right buttock. She removed her gloves, washed her hands and donned clean gloves. She then cleansed each area with moistened normal saline gauze pads. After cleansing the areas, the Wound Nurse removed her gloves and donned clean gloves. She did not wash her hands or use hand sanitizer before applying the clean gloves. A calcium alginate dressing was applied to the sacrum, right hip and right buttock. The Wound Nurse removed her gloves after applying calcium alginate to each wound, however, she did not wash her hands or use hand sanitizer before donning clean gloves. The Wound Nurse proceeded to remove the dressing to the resident's left hip. She removed her gloves and donned clean gloves without performing hand hygiene. She cleansed the area with normal saline, removed her gloves and donned clean gloves without performing hand hygiene. She then proceeded to cover the area with calcium alginate. She removed her gloves		wound care - Ensure staff involved are educated for hand hygiene and understand when to perform hand hygiene. - Ensure staff involved are educated on when to don and doff gloves Policy: PPE Gloves **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** A Root Cause Analysis (RCA) was conducted with the Infection Preventionist (IP) and input from the IDT and the facility Medical Director/IP/DON. The root cause was identified resulting in the facility's failure. Solutions were developed and systemic changes were identified that need to be taken to address the root cause. The Infection Preventionist and IDT reviewed the LTC infection control self-assessment and identified changes to make accurate **How the corrective measures will be monitored to ensure the**	

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	and donned clean gloves without performing hand hygiene. After completing the treatment to the left hip, the Wound Nurse removed her gloves and performed hand hygiene with hand sanitizer. Interview with the Nurse Consultant on 9/30/21 at 4:25 p.m., indicated the Wound Nurse should have either washed or sanitized her hands each time before and after donning gloves. Review of the Personal Protective Equipment (PPE) Gloves policy on 9/30/21 at 4:23 p.m., provided by the Nurse Consultant and identified as current, indicated hand hygiene was to be performed before donning and after doffing gloves. 3. During an observation of morning care on 9/29/21 at 9:50 a.m., Resident B was observed in bed. At that time, CNA 5 and CNA 3 performed hand hygiene and donned a pair of clean gloves to both hands. CNA 3 gathered the supplies for the bath and CNA 5 washed the resident's chest, under his arms and peri area. She then helped him rinse and dry with a towel. CNA 5 changed the bath water and removed her gloves and donned a new pair of gloves, without performing hand hygiene. CNA 3 was observed removing her gloves and donned a clean pair of gloves and did not perform hand hygiene. She assisted CNA 5 with turning and repositioning the resident. CNA 5 cleaned bowel movement on the resident and after she was finished, she removed her gloves and donned a clean pair of gloves to both hands. She did not perform hand hygiene. LPN 2 came down to the room to apply the medicated powder to the resident's abdominal fold and neck. She donned a pair of clean gloves and applied the powder to his abdominal fold. The LPN removed her gloves and donned a clean pair without performing hand hygiene and applied the powder on his neck.		**alleged deficient practice does not recur:** After the IDT and Infection Preventionist completed the RCA and LTC infection control assessment, training identified above was implemented to facility staff. The training will be conducted by the DON, IP or Medical Director with documentation of completion. To ensure Infection Control Practices are maintained, the following monitoring will be implemented. 1. The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA and as noted above, daily or more often as necessary for 6 weeks and until compliance is maintained. Ensure staff execute infection control practices regarding resident wound care – hand hygiene after doffing gloves Ensure staff execute hand hygiene after doffing of gloves during resident care Ensure staff execute doffing of gloves before exiting a resident room – gloves are not to be worn in the hallway 2. The IP nurse/DON/Designee	

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	Interview with both CNAs on 9/29/21 at 10:25 a.m., indicated they were aware they needed to perform hand hygiene after removing gloves. Interview with the West Unit Manager on 10/1/21 at 10:10 a.m., indicated hand hygiene was to be performed before and after glove removal. 3.1-18(b) 3.1-18(l)		will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified as above. This will occur for 6 weeks and until compliance is maintained. Ensure staff execute infection control practices regarding resident wound care – hand hygiene after doffing gloves Ensure staff execute hand hygiene after doffing of gloves during resident care Ensure staff execute doffing of gloves before exiting a resident room – gloves are not to be worn in the hallway **Quality Assurance and Performance Improvement (QAPI):** The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure			

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	that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse			

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	immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on record review and interview, the facility failed to ensure residents were offered the pneumonia vaccine for 3 of 5 resident records reviewed for immunizations. (Residents D, 54 and 23) Finding includes: The resident immunization records were reviewed on 10/1/21 at 9:20 a.m.: a. Resident C's immunization record had no information related to the pneumonia vaccine being administered or refused. b. Resident 54's immunization record indicated a pneumonia vaccine consent was required. There was no date indicated. c. Resident 23's immunization record had no information related to the pneumonia vaccine being administered or refused. Interview with the EHR (electronic health records) nurse on, 10/1/21 at 11:05 a.m., indicated there were no consents or refusals signed for the pneumonia vaccine for the above residents.	F 0883	**F 883** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident D remains confidential as part of the complaint survey Resident 23 and 54 will be offered the pneumonia vaccine and consent, refusal and administration will be documented. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DON or designee will audit all current residents medical records to ensure the pneumonia vaccine has been offered and consent, refusal, administration has been documented. **Measures put in place and systemic changes made to ensure the alleged deficient**	11/08/2021

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	3.1-18(b)(5)		**practice does not recur:** DON or designee will re-educate the Licensed Nurses on the following policy: Resident Immunization Overview **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits for all new admissions will be conducted on-going: ensure the pneumonia vaccine has been offered and consent, refusal, administration has been documented. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	
F 0886 SS=D Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on			

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	parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the			

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	155218	A. BUILDING 00 B. WING	10/04/2021

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	transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.			
	Based on record review and interview, the facility failed to conduct COVID-19 testing for staff per guidelines for 3 of 3 staff records reviewed. (RN 1, CNA 2, and CNA 1) Finding includes: The employee COVID-19 testing records, for the past four weeks were reviewed on 9/30/21 at 5:35 p.m. RN 1, an unvaccinated employee, was tested for COVID-19 on 8/30, 9/7, 9/14, 9/16, 9/21 and 9/23. The record lacked testing results for 9/2, 9/9 and 9/28. CNA 2, an unvaccinated employee, was tested on 8/30, 9/7, 9/14, 9/16, 9/21 and 9/28. The record lacked testing results for 9/2 and 9/9. CNA 1, an unvaccinated employee, was tested for COVID-19 on 8/30, 9/7, 9/14, 9/16, 9/21, and 9/23. The record lacked testing results for 9/2, 9/9 and 9/28.	F 0886	**F 886** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** All residents have the potential to be affected by this alleged deficient practice. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DON or designee will ensure all current unvaccinated employees are tested at the frequency prescribed in the routine testing table based on the level of community transmission. See the Indiana Department of Health document “Long-term Care Covid-19 Clinical Guidance”	11/08/2021

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	The Indiana Department of Health document, "Long-term Care COVID-19 Clinical Guidance", updated 9/7//21, testing table indicated when community COVID-19 activity was high, greater than 10% positivity rate, unvaccinated staff should be tested a minimum of two times weekly. Interview with the Director of Nursing, on 10/1/21 at 9:35 a.m., indicated the county positivity rate had been over 10% for the past month and unvaccinated staff were being tested twice weekly on Tuesday and Thursday. She indicated there were no additional testing results for the above staff. 3.1-18(b)		**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Director of Nursing Services or designee will re-educate the Licensed Nurses on the following policy: Indiana Department of Health document “Long-term Care Covid-19 Clinical Guidance” **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audit for 10 unvaccinated employees will be conducted by the Director of Nursing Services or designee 2x per week x 90 days to ensure all current unvaccinated employees are tested at the frequency prescribed in the routine testing table based on the level of community transmission. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	