STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155203	A. BUILDING 00 B. WING	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HILLCREST VILLAGE	203 SPARKS AVE JEFFERSONVILLE, IN 47130

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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 IN00420944 and IN00423583. Complaint IN00423583- Federal/State deficiencies related to the allegations are cited at F609. Complaint IN00402944- No deficiencies related to the allegations are cited. Survey dates: December 10, 11, 12, 13, and 14, 2023 Facility number: 000110 Provider number: 155203 AIM number: 100271120 Census Bed Type: SNF/NF: 101 SNF: 15 Total: 116 Census Payor Type: Medicare: 9 Medicaid: 75 Other: 32 Total: 116 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 21, 2023.	F 0000	=”” p=””> This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after (1/5/24)	
F 0554 SS=E Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer			

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

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	medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure appropriate oversight of medication administration during 5 of 25 random observations. (Residents 104, 12, 98, 134, and 97) Findings include: 1. During an observation on 12/11/23 at 9:05 a.m., Resident 104 was resting abed, finishing her breakfast. There was a medication cup containing 1 clear yellow capsule, 1 red oblong capsule, 1 small green oblong tablet, 1 white round scored tablet, 1 white round unscored tablet, 1 large white oblong tablet, and 1 small pink oval tablet. The nurse was not within sight. During an interview on 12/111/23 at 9:06 a.m., Resident 104 indicated the pills in the cup were her morning medications. Staff typically left her medication on the table. She was going to take them in a little while. They'd been brought to her about 5 to 10 minutes prior. During an interview on 12/11/23 at 9:14 a.m., RN 20 indicated she didn't know if the resident typically kept her medications at bedside. She usually watched the residents take them. She entered the room and observed the medication cup. She asked Resident 104 if they were her medications and the resident indicated they were. The nurse indicated she guessed they were from that morning. She was not certain if the resident had been assessed to take medication by herself or have medications left at the bedside. She did not typically leave medications at the bedside, but Resident 104 was "usually with it." The medications in the cup were	F 0554	**F – 554 - Self-Admin Meds** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** Unit Manager followed up with Residents 104, 12, 98, 134 and 97 all rooms were searched, and no meds were found at bedside, all residents stated that they had all taken their medications. Resident 97's order for Synthroid was verified and active since 6/6/23. Meds for these residents are no longer left at bedside and are observed to take the medication as prescribed. Resident 12 is observed by a licensed nurse during the nebulizer treatment and documented in the resident's chart. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. On 12/11/23, DNS/designee began in-servicing all licensed and qualified staff on Medication Administration Procedure. DNS/Designee observed all other resident rooms to ensure meds were not left at bedside and to	01/05/2024

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	the resident's vitamin C, Eliquis, garlic, potassium, sertraline, Thera M plus, and zinc. The record for Resident 104 was reviewed on 12/11/23 at 10:00 a.m. The diagnoses included, but were not limited to, depression, vitamin D deficiency, and saddle embolus of pulmonary artery with acute cor pulmonale. The Quarterly MDS (Minimum Data Set) assessment, dated 10/24/23, indicated the resident was moderately cognitively impaired. The physician's current orders indicated the resident was receiving garlic 1000 milligrams (mg) daily, sertraline 25 mg daily, Eliquis 5 mg twice daily, potassium chloride 20 meq daily, vitamin C 500 mg daily, and Thera M plus multivitamin 1 tablet daily. The MAR indicated the medications were last documented as administered on 12/11/23 between 7:00 a.m. and 11:00 a.m., by RN 20. The resident's record lacked documentation of any orders, care plan, or assessments for the resident to self-administer medications, or any orders for the resident's medications to be left at her bedside. 2. During an observation on 12/11/23 at 10:38 a.m., Resident 12 was resting abed self-administering a nebulizer treatment. The nebulizer machine was running, the resident had the mouthpiece in her mouth and was inhaling the vapor, which could be seen exiting the end of the mouthpiece upon the resident's exhalation. There was an albuterol sulfate HFA 90 mcg/act (micrograms per actuation) inhaler lying on her bedside table. The nurse was not in sight.		ensure nurse observed nebulizer treatments as ordered. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** On 12/15/23, DNS/designee began conducting daily room rounds to ensure medications were not left at bedside using a Medication Storage QAPI tool. Any Medications found at bedside will be identified and the nurse responsible will receive additional education and or appropriate disciplinary action. DNS/Designee will round to ensure residents are observed during nebulizer treatments per MD order. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** The DNS/designee will be responsible for the Medication Storage QAPI tool weekly times 4 weeks, then monthly times 6, then quarterly thereafter until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI Committed overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed. **5.** Date of compliance: 1/5/24.	

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	During an interview on 12/11/23 at 10:39 a.m., Resident 12 indicated the nurses brought her breathing treatments to her but did not stay in the room with her while she administered it. The record for Resident 12 was reviewed on 12/11/23 at 12:30 p.m. The resident's diagnoses included, but were not limited to, COPD and chronic respiratory failure. The Significant Change MDS assessment, dated 11/6/23, indicated the resident was cognitively intact. The physician's current orders indicated the resident was receiving albuterol sulfate HFA 90 mcg/act (micrograms per actuation) 2 puffs inhaled every 6 hours as needed, budesonide 0.5 mg per 2 mL 1 vial twice daily, and ipratropium-albuterol 0.5 mg per 3 mL 1 vial every 6 hours. The December MAR indicated the following: - There were no administrations of the resident's albuterol sulfate HFA 90 mcg/act documented in the month of December. - The resident's budesonide 0.5 mg per 2 mL was last documented as administered between 7:00 a.m. and 11:00 a.m. on 12/11/23. - The resident's ipratropium-albuterol 0.5mg per 3 mL was last documented as administered at 10:00 a.m. The resident's record lacked documentation of any orders, care plan, or assessments for self-administration of medications, or any orders for the resident's medications to be left at her bedside.			

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	3. During an observation on 12/13/23 at 12:45 p.m., Resident 98 was resting abed with her eyes closed. There was a medication cup on the table with 2 white tablets imprinted TCL 340. The nurse was not in sight of the room or the medication. The nurse was down the hall preparing another resident's medication. During an interview on 12/13/23 at 12:47 p.m., LPN 21 indicated she would have sworn the resident took the medication when she gave it to her. She had taken the medication in about 10 minutes prior, it was the resident's Tylenol. The resident's diagnoses included, but were not limited to, cognitive communication deficit, lack of coordination, muscle weakness, and personal history of transient ischemic attack. The Quarterly MDS assessment, dated 10/6/23, indicated the resident was moderately cognitively impaired. The physician's current orders indicated the resident was receiving Tylenol 325 mg 2 tablets 4 times daily for pain. The MAR indicated the medication was last documented as administered by LPN 21 on 12/11/23 at 12:00 p.m. The resident's record lacked documentation of any orders, care plan, or assessments for the resident to self-administer medications, or any orders for the resident's medications to be left at her bedside. 4. During an observation on 12/11/23 at 9:29 a.m., a liquid medication in a medication cup and two tablets in another medication cup were observed			

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	on the bedside table of Resident 134. On 12/11/23 at 10:42 a.m., LPN 14 was asked to return to Resident 134's room to identify the medications at her bedside. LPN 14 asked the resident to take her medications. The LPN indicated the tablets were metformin and Buspar and the liquid medication was a protein. The record for Resident 134 was reviewed on 12/12/23. The diagnoses included, but were not limited to, type 2 diabetes mellitus, generalized anxiety disorder, and depression. The care plan, dated 11/17/23, indicated the resident was at risk for adverse side effects related to the use of psychotropic medication related to antianxiety, antidepressant and hypnotic medications. The interventions, dated 11/17/23, included, but were not limited to, administer medications as ordered, observe for effectiveness, document side effects as observed and notify the MD. The care plan, dated 11/17/23, indicated the resident was at risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnoses of diabetes mellitus. The interventions, dated 11/17/23, included, but was not limited to, administer medications as ordered. The physician's current order, dated 11/17/23, indicated to administer metformin 1000 mg twice daily at 8:00 a.m. and 5:00 p.m., given with meals for the diagnoses of type 2 diabetes mellitus. The MDS (Minimum Data Set) Admission assessment, dated 11/23/23, indicated the resident was cognitively intact.			

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The physician's order, dated 11/27/23, indicated to administer buspirone 10 mg (milligrams) three times daily for generalized anxiety disorder.

The physician's order, dated 11/27/23, indicated to administer ProSource liquid 10-100 grams-kcal/30 mL (milliliters) daily to promote wound healing.

During an interview on 12/12/23 at 8:52 a.m., LPN 14 indicated when administering a resident's medication she should make sure the resident took the medication in front of her.

5. During an observation on 12/12/23 at 8:27 a.m., Resident 97 walked out of her room to LPN 15 in the hallway, by the medication cart, and indicated her pills were on her bedside table from the night shift. She had missed her 4:00 a.m. levothyroxine and it was not in her medications.

On 12/12/23 at 8:33 a.m., Unit Manager 16 and LPN 15 entered the resident's room and obtained the medications. The resident indicated she had not received her levothyroxine a lot of times. The resident indicated if the levothyroxine was there, it was lost.

On 12/12/23 at 8:42 a.m., Unit Manager 16 indicated the identity of the 4 tablets in the cup. The medications were; gas relief 80 mg, 2 tablets and Acetaminophen 325 mg, 2 tablets.

The resident's diagnoses included, but were not limited to, type 2 Diabetes Mellitus and rheumatoid arthritis.

The Quarterly MDS assessment, dated 9/18/23, indicated the resident was cognitively intact. She required extensive assistance for ambulation and

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	transfers. The care plan, dated 1/19/23, indicated the resident was at risk for pain related to decreased mobility and fibromyalgia. The interventions included, but were not limited to, administer medications as ordered, document effectiveness of p.m. medications, and notify the MD if pain was unrelieved and/or worsening. The December MAR (Medication Administration Record) for 12/12/23, lacked documentation of the administration of 2 tablets of acetaminophen 325 mg. The physician's orders lacked documentation of an order for the resident to receive Gas Relief or levothyroxine. The physician's orders, dated 1/18/23, indicated the administer acetaminophen 325 mg 2 chewable tablets every 4 hours as needed. On 12/12/23 at 8:46 a.m., Unit Manager 16 indicated when medications were found at a resident's bedside, the Unit Manager should be notified. The nurse should have let the resident know they had their medication and watched the resident take their medication. The night shift nurse was LPN 17 and she had left the medication on the bedside table for Resident 97. During an interview on 12/12/23 at 9:18 a.m., Unit Manager 16 indicated Resident 97 was not on levothyroxine, and did not have an order for it. During an interview on 12/12/23 at 10:00 a.m. the DON indicated the facility did not have Self Administrations of Medication Assessments for residents.			

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	Cross Reference F565. 3.1-11(a)			
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.			

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	§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on record review and interview, the facility failed to act upon resident concerns of food temperatures, taste of food, drinks not being passed at meal times, and medications being left at bedside for 8 of 13 Resident Council meetings (December 2022, January, February, April, June, August, November and December 2023) and for 6 of 10 Food Advisory Committee meetings (June, July, September, October, and 2 in November 2023). This deficient practice had the potential to affect 116 residents currently residing in the facility. Findings include: The Resident Council Meetings between December 2022 and December 2023 indicated the following concerns were not acted upon or resolved: - On 12/27/22, the temperature of the food was not appropriate and the food was too cold or just room temperature. No follow up response to this concern. - On 1/25/23, the temperature of the food was not appropriate and the meats were cold. The response from the Dietary Manager on 1/27/23 was that an inservice was held with all production personnel with a reminder for temperature checks throughout the meal. - On 2/28/23, the temperature of the food was not appropriate, the salads were getting hot and were	F 0565	**F – 565 – Resident / Family Group and Response** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** No residents have been identified as affected by the alleged deficient practice. Resident concerns voiced during Council have follow up completed and documented and discussed with the council the next meeting. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. On 12/27/23, ED in-serviced all department managers on Food Advisory Committee and Resident Council policies and procedures. ED also reviewed the meeting minutes and follow up forms completed for the 12/12/23 resident council meeting. All concerns were noted, and follow-ups completed. **3: What measures will be put into place or what systemic**	01/01/2024

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	wilted due to them being put on the hot plate. The response from the Dietary Manager, on 3/1/23, indicated the production staff were informed of the steps required for temperature control with food. - On 4/25/23, the food was lacking seasoning, flavorings and spices. No response or follow up to this concern. - On 6/27/23, the temperature of the food was not appropriate and the food was coming out cold. Residents indicated they did not receive drinks with their meals, mainly at lunch. The response from the DHS (Director of Health Services), on 6/30/23, indicated staff would be inserviced on proper meal time protocols. - On 8/29/23, the temperature of the food was not appropriate, and weekend meals were coming out cold. There was no response or follow up to this concern. - On 11/28/23, the temperature of the food was not appropriate and the food did not look or taste good. Several residents indicated they were not getting drinks for lunch on 2 Southeast Hall, 2 South Hall and 2 West Hall. The response from the DHS, on 11/28/23, indicated the Unit Managers were to observe meal service to ensure drinks are passed with lunch. Review of the June to December 2023 Food Advisory Committee Meeting notes indicated the following concerns were not addressed: - On June 8, 2023, CNAs (Certified Nurse Aide)		**changes will be made to ensure that the deficient practice does not recur?** SED and CDM will conduct monthly food committee and resident council meetings using a resident council Audit tool to ensure process completion. The meeting minutes will be reviewed and signed with the Resident Council President and any concerns mentioned during the meetings will be noted on a resident council meeting follow-up form, given to the ED and designated department manager to implement corrective action. Follow-up will be provided to the council members during next monthly council meeting. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** The SED and CDM will be responsible for the completion of the meeting minutes, follow-up forms and Council QAPI audit tool and follow-up to the council members. The audit tools along with the meeting minutes and follow up forms will be reviewed monthly by the QAPI Committed overseen by the ED. If a threshold of 90% is not achieved, or repeat concerns are noted, an action plan will be developed. **5.** Date of compliance: 1/1/24	

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	were not giving drinks to the residents at meal. - On July 20, 2023, CNAs were not giving drinks to the residents at meals. - On September 21, 2023, snacks were not being passed at night and staff were heard to say they were taking the home to their kids. - On October 5, 2023, snacks sometimes were not passed out until around midnight; the selective menus were not being followed; and the broccoli and cauliflower was so hard as it was not done enough. - On November 2, 2023, the food was not hot or cold enough. - On November 16, 2023, Dinner came out late more often than not. During the Resident Council meeting on December 12, 2023, between 2:00 p.m. and 2:40 p.m., 11 residents were present. The Activities Director indicated all 11 residents were alert and oriented, and regularly attended the meeting, the following concerns were voiced: - 4 of the 11 residents indicated they were diabetics and that the CNAs (Certified Nurse Aide) were not always coming around and offering a bedtime snack. Even if a resident asked for one, staff would not get them one as they would indicate the requested item was not available. One resident indicated that if residents did not eat their dinner meal, a snack was needed to hold them over until breakfast the next day and that was a long time to go without something to eat between lunch and breakfast the next day.			

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	- Evening meal tended to get to the floor by 6:30 to 7:00 p.m., sometimes it had been 8:00 p.m.., and residents were never told why it was late which happened frequently. - The lunch trays today never came to the 2nd floor until 1:40 p.m. West Hall was always served last. One resident indicated he had just received his lunch tray right before the Resident Council meeting today and did not have time to eat. The dining room was served by 12:30 p.m. and then 2nd floor was supposed to receive their trays shortly afterwards. - The food was cold frequently, no particular meal was more of a problem than others. Some of the aides would heat it up and some won't. - They do not always get something to drink with their meals as the drink cart did not make it around to everyone. The cart was often seen on the hall just sitting there. The aides would pass drinks only to their section of people, but no one made sure the other residents on the hall had their drinks. Or the cart came long after the residents had finished their meal. The residents wanted their drinks with their trays.- Resident 62 indicated the nurse left his aspirin at bedside and did not wait for him to take it. He indicated he would get to it at some point and take it. The resident's Annual MDS assessment, dated 10/12/23, indicated the resident had moderate cognitive impairment and required cues for recall. - Resident 71 indicated staff had a hard time waking her up between 4:00 to 6:00 a.m. If they were unable to wake her, then they would leave her medication at bedside for her to take when she did become awake. The nurse was not there when she took her medication. The Annual MDS			

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	155203	A. BUILDING 00 B. WING	12/14/2023

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	assessment, dated 11/8/23, indicated the resident was cognitive intact. - Resident 20 indicated if she was not awake when they came in to give her the morning medications, they would leave them at beside and leave the room. She indicated she would take them when she got up. The Annual MDS assessment, dated 9/13/23, indicated the resident was cognitively intact. - Resident 85 indicated some nurses would drop her medications off at bedside and she would take them later without them present. The Quarterly MDS assessment, dated 9/27/23, indicated the resident had trouble remembering the year but otherwise was cognitively intact. The facility's current policy titled Resident Council included, but was not limited to, "Policy: The facility will promote and support the resident's right to participate and organize resident council. The council will be used to communicate concerns...and guide facility life. Procedure:...6. Concerns or suggestions from the meeting will be addressed by the appropriate department. The Executive director will review all minutes and concern to ensure thorough resolution of concerns..." The facility's current policy titled Food Advisory Committee included, but was not limited to, "Policy: Resident Food Advisory Committee meetings will be held routinely to obtain input from residents on the menu, to review meal service...Procedure: 4. Concerns/suggestions related to meals or meal service will be documented and addressed as needed. Follow up will be reviewed with the committee at the next scheduled meeting to ensure resolution."			

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	Cross Reference F554, F804, F809 3.1-3(l)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to report an allegation of neglect and	F 0609	**F – 609 – Reporting of Alleged Violations**	01/05/2024

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	mistreatment to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services) in accordance with State law through established procedures for 1 of 2 residents reviewed for abuse. (Resident B) Findings include: The record for Resident B was reviewed on 12/12/23 at 10:00 a.m. The diagnoses included, but were not limited to, malignant neoplasm of pancreas, unspecified, malignant neoplasm of unspecified part of unspecified bronchus or lung with chemotherapy, dysarthria following cerebral infarction, chronic obstructive pulmonary disease, and occlusion and stenosis of unspecified carotid artery. The 5 Day Minimum Data Set (MDS) assessment, dated 10/29/23, indicated the resident was alert and oriented, had no mood issues and occasionally refused care. The Behavioral Health Monthly Review, dated 11/13/23, completed by the Social Worker, indicated the resident had new/worsening behavior of refusal of care and had intermittent confusion. During an interview with Unit Manager 3 on 12/10/23 at 10:00 a.m., she indicated the resident had a tendency to be argumentative and was confused at times, but usually was okay. During an interview with Unit Manager 3 on 12/11/23 at 9:10 a.m., she indicated the resident was getting more confused and that she would tell stories about staff not caring for her. The other day she was at an appointment, she told everyone		**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** The allegation regarding resident B was immediately reported to ISDH and APS in accordance with company policy and an investigation was initiated. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. On 12/14/23, ED/designee began in-servicing all staff on the facility's abuse prohibition, prevention, and reporting policy and the zero-tolerance position of the facility. The Unit Manager was interviewed and issued appropriate disciplinary action. All interview able residents were interviewed by care companions using QIS abuse/neglect questions to ensure no other concerns were identified. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** On 12/27/23 DNS/designee began completing an Abuse-Staff Interview QAPI tool to ensure on going and continued education regarding abuse prohibition,	

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	no one would give her a shower, food to eat, and they slapped her around. Human Resources reported it to her and when she checked on her the next day, she said everything was fine with no issues. She did not report it to the Director of Nursing (DON) or to the Executive Director (ED). On 12/12/23 at 9:30 a.m., a request for the Reportable Incidents to State in last six months was requested from the DON and ED. The Reportables lacked documentation of the incident being reported to the State. During an interview on 12/14/23 at 8:40 a.m., with the Human Resources Director, he indicated he did not initially recall the resident making any statements about not being treated right at the facility as he only dropped her off and then later picked her up. He did indicate the resident was upset when he picked her up and reported to Unit Manager 3 that the resident had said something about someone was being mean to her. During an interview with the DON on 12/14/23 at 9:00 a.m., she indicated she had spoken with Unit Manager 3, who told her the chemotherapy center called her and said Resident B was making statements at the chemotherapy center about the facility being mean to her and when she later spoke with the resident, she was better, so she didn't report the incident to either her or the ED. The allegation of mistreatment was not reported to the State like it should have been. The computer based employee training indicated Unit Manager 3 completed the Elder Justice Act and Abuse Recognition, Prohibition and Reporting inservice on 1/5/23 and The Guardian/Abuse inservice on 11/6/23.		prevention, and reporting. Any staff members that do not answer the interviews correctly will receive additional education and any concerns noted will be reported in accordance with facility policy. ED to attend the next resident council with permission, to inquire if any residents have experienced abuse/neglect, and to encourage residents to report concerns immediately. Any concerns will be reported and investigated per protocol. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** The DNS/designee will be responsible for the Abuse – Staff Interview audit tool weekly times 4 weeks, monthly times 3, then quarterly thereafter until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI Committed overseen by the ED. If a threshold of 90% is not achieved, an action plan will be developed. **5.** Date of compliance: 1/5/24	

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	The facility's current policy titled Abuse Prohibition, Reporting, and Investigation included, but was not limited to, "...Policy: It is the policy of [name of facility] to provide each resident with an environment that is free from abuse, neglect...Education/Training: 1. Employees, whether direct care, contract staff, ancillary departments,...receive instruction/training on abuse during orientation and periodically during ongoing in-service education. The education/training will include:...b. Identifying what constitutes abuse, neglect...d. Reporting abuse, neglect...e. who and when staff and others must report their knowledge related to any alleged violation..Reporting/Response: 1. All abuse allegations must be reported to the Executive Director immediately...2. The Executive director will ensure all alleged violations involving abuse, neglect...are reported not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Long Term Care Division of the Indiana State Department of Health via the Gateway Portal..." This citation relates to Complaint IN00423583 3.1-27(a)(3)			
F 0745 SS=E Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure appropriate social services follow-up and monitoring of residents with hallucinations, concerns, and mood changes for 4	F 0745	**F – 745 – Provision of Medically Related Social Services** **1: What corrective action(s) will be accomplished for those**	01/05/2024

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	of 5 residents reviewed for Social Services (Residents 2, 12, 79, and 115) Findings include: 1. The clinical record for Resident 2 was reviewed on 12/11/23 at 11:54 a.m. The diagnoses included, but were not limited to, schizophrenia, anxiety disorder, depression, and insomnia. The Quarterly MDS (Minimum Data Set) assessment, dated 10/20/23, indicated the resident was cognitively intact. The current physician's order indicated the resident was to receive buspirone 30 mg (milligrams) oral twice a day, with a start date of 9/18/23; Clonazepam 0.5 mg oral twice a day, with a start date of 12/2/22, Clozapine 100 mg oral, three times a day; given with a 50 mg tablet to equal 150 mg, with a start date of 1/31/23; Clozapine 50 mg oral, three times a day; give with a 100 mg tablet to equal 150 mg, with a start date of 1/31/23; and Trazodone 100 mg oral at bedtime, with a start date of 3/14/23. The resident may receive psychiatric services, with a start date of 12/13/23. The care plan, dated 12/16/21 and revised on 11/24/23, indicated the resident was at risk for signs and symptoms of depression. The interventions included, but were not limited to, the resident would have no increase in symptoms of depression aeb (as evidenced by) PHQ-9 (Patient Health Questionnaire) score and observations of signs and symptoms of depression, encourage family support and involvement, obtain a psychiatric consult or a psychotherapy consult, allow the resident to express his feelings and frustrations, offer validation and support, and encourage activities of interest.		**residents found to have affected by the deficient practice?** Resident 2, 12, and 79 all receive treatment from Psych Services, resident 115 refuses. Resident 2 was seen on 12/4, reported no concerns. Resident 12 was last seen on 12/18, reported no concerns and Care plan was updated to include history of hallucinations. Resident 79 was seen on 12/18 also reporting no concerns. Resident 115 participated in Care Plan meeting with BOM and SSD on 12/19 to discuss potential DC plan. Residents 2,12,79, and 115 had social service follow up visits conducted and was documented in the resident chart. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. On 12/18, ED and DNS educated Psych NP on facility grievance process to communicate resident concerns not related to Psych scope of practice. On 12/26 SSD, SSA, IDT and Nursing staff were educated on the facilities Behavior Management policy to ensure that each resident receives the necessary behavioral health care services to maintain	

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	The clinical record lacked documentation indicating the Social Services staff follow up visits were completed. The Social Services note, dated 1/9/23 at 2:24 p.m., indicated the resident's PHQ9 and the assessment was high at 14, indicating depression. During the interview with the resident, he indicated he had been feeling down or depressed. He found little interest in doing things, had trouble staying asleep, and he had trouble with his appetite. He felt like a failure on some days. The Social Service Significant Change note, dated 2/24/23 at 1:06 p.m., indicated the residents PHQ9 score was 00 showing no depression. The assessment indicated the resident had delusions and had difficulty sleeping, anxiety, and smoking. The Social Service note, dated 5/12/23, indicated the residents PHQ-9 was a score of 11. The resident indicated he found little to no interest in doing things, poor appetite, feels down and depressed most days, had trouble staying asleep most nights, feels restless most nights, and tired most days. The psychiatric notes, dated 5/15/23, indicated the resident was seen for a follow up psychiatric visit to assess and manage his chronic mental health illnesses. His symptoms were chronic, moderate in severity, ongoing, intermittent and he does not respond to medicine. On the exam, the resident was seen seated on the side of his bed. He was awake, alert and in no acute distress. When he was asked how he was he indicated he was doing pretty good he thought. He was not sleeping good at all and did not know why. He would walk to try to get exercise. He felt his		the highest practicable physical, mental, and psychosocial well-being. Social Service reviewed resident charts to ensure those residents who indicated depression per PHQ9 indicator, experienced hallucinations, and behaviors, have had social service follow up. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** SSD/designee will review all new and worsening behaviors daily with the IDT members using a Behavior Management Audit Tool. All new and worsening behaviors will be assessed for other potential contributing factors or root causes and an intervention will be put in place. IDT will review resident medical record and ensure social service follow up is completed and documented for residents who experience depression, hallucinations, and behaviors. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** The SSD/designee will be responsible for the completion of the Behavior Management Audit Tool daily times 4 weeks, weekly times 4, monthly times 3 then quarterly thereafter until continued	

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	appetite was ok, but he could be a little depressed. He would read the Bible every day, and felt like people up in heaven were looking down on him. He worried about not being busy enough. He would tell himself to have patience, any one could come see him when they needed him. He would have hallucinations only if he stared at something really small. The resident had a blunted affect. The Social Services progress note, dated 8/3/23 at 7:30 p.m., indicated the resident reported during his mood interview that he got depressed sometimes, had not been sleeping, had little energy, and had trouble concentrating on things. The residents PHQ9 assessment score was an 11. The Social Service note, dated 8/30/23, the resident indicated "I feel like my cranium is splitting apart. I don't play with my body, and my head starts to hurt." He did not play with his body because his head started to hurt. He went to see if his spending money was there, and he was told no. People can be argued with and get anything done. He thought maybe it got lost. He wanted a soda pop and indicated it wouldn't hurt if he only drank one. The resident indicated he drank ten 2 liters and had to go to the hospital. He wasn't supposed to drink soda pop that fast because it wasn't good for you. He got hungry, but he didn't want to eat all of his food. He was worried he might get mad because he got irritated easy. He felt irritated because he compared himself to other people. He had been seeing a psychiatrist since he was 17 years old. He indicated he was anxious and upset. He had double vision when watching television. During an interview on 12/14/23 at 9:30 a.m., RN 19 indicated the resident's behavior and mood was stable at that time. He did see psychiatric and she		compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI Committed overseen by the ED. If a threshold of 90% is not achieved, an action plan will be developed. **5.** Date of compliance: 1/5/24	

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	thought his depression was stable. Staff would encourage the resident to come out of his room and join in on activities. Sometimes he would attend the activities. He was kind of a loner. He walked several times a day for exercise. During an interview on 12/14/23 at 10:30 a.m., SSA (Social Service Assistant) indicated the PHQ9 was a form used to indicate the residents mental health status. If the resident had a resident that scored a 14 on the PHQ9 and then a month later the resident was a 0, she would review the resident's psychiatric notes, follow up on the previous PHQ9, look at medications, and follow up with the resident in a few days, and document in the clinical record. The SSA indicated a follow up progress note should have been made in the clinical record when the PHQ9 was 14, then went to 0 and then back to 13. She would question if the assessment was accurate or not. 2. The record for Resident 12 was reviewed on 12/12/23 at 9:35 a.m. The diagnoses included, but were not limited to, bipolar disorder and generalized anxiety disorder. The Significant Change MDS assessment, dated 11/6/23, indicated the resident was cognitively intact. The care plan, dated 4/24/23, indicated the resident was at risk for signs and symptoms of depression. The interventions included, but were not limited to, allow the resident to express feelings and frustrations, offer validation and support, emphasize and promote independence and feelings of control/choice, encourage activities of interest, encourage family support and involvement, medications per order, obtain psychological consult and psychotherapy consult.			

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The resident's care plan lacked interventions or a plan of care specific to the resident's history of hallucinations.

The Psychiatric NP (Nurse Practitioner) note, dated 5/15/23 at 6:16 a.m., indicated the resident was seen for a psychiatric evaluation. She had a history of bipolar disorder and generalized anxiety disorder. Her symptoms were chronic and moderate with intermittent disturbances. She reported having a nervous breakdown when her spouse passed which required inpatient treatment. She was estranged from her family member. She had been hospitalized with hallucinations. Her consultations for treatment included the Social Worker. She would benefit from psychotherapy due to grief and persistent depression.

The nurse's note, dated 9/16/23 at 7:07 a.m., indicated the resident was hallucinating. Her roommate stated the resident was seeing dead people. Her respirations were 30, her blood pressure was 95/54, her oxygen was 89% on 2 lpm, her pulse was 50, and her respirations were labored. She was sent to the hospital.

The Psychiatric NP note, dated 9/25/23 at 6:17 a.m., indicated the resident was seen for a psychiatric medication visit. She reported hallucinations, which included seeing forms above the TV when she was watching TV. The forms were friendly and grinned. Her consultations for treatment included the Social Worker.

The Psychiatric NP note, dated 10/9/23 at 6:11 a.m., indicated the resident reported seeing trolls or something in the corner above the TV. They waved at her. It scared her. One turned into her

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	mother that day and it really scared her. The resident had increased visual hallucinations which were causing her distress. She was started on Seroquel 12.5 mg for the hallucinations. The consultations for treatment included the social worker. The Psychiatric NP note, dated 10/30/23 at 6:20 a.m., indicated the resident reported she was hallucinating again. It started 2 to 3 days prior. She was having weird hallucinations. She was seeing her multiple deceased family members. She was referred to psychotherapy for medical concerns and lack of family support. Consultations included the social worker. The record lacked documentation of any psychosocial follow-up with the Social Worker on the reported concerns of the resident experiencing visual hallucinations. During an interview on 12/13/23 at 1:19 p.m., the SSD (Social Services Director) indicated she had been the SSD for over a year. She knew Resident 12 had a history of hallucinations and at one time the Psychiatric NP had told her about it but it wasn't anything recent. She certainly had a history of hallucinations, but she herself was not doing any monitoring of the hallucinations or following up with nursing staff on whether or not the resident had continued concerns. That was something she left to the psychiatric provider. During an interview on 12/14/23 at 1:55 p.m. CNA 23 indicated she did take care of Resident 12 regularly. Sometimes she got a little upset, but she hadn't mentioned having hallucinations. She was not aware the resident had a history of hallucinations. No one had ever discussed with her how to address that.			

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	3. The record for Resident 79 was reviewed on 12/12/23 at 12:55 p.m. The diagnoses included, but were not limited to, anxiety, depression, schizophrenia, bipolar disorder, and tobacco use. The Quarterly MDS assessment, dated 11/17/23, indicated the resident was cognitively intact. The Psychiatric NP note, dated 8/28/23 at 6:21 a.m., indicated the resident needed more pods for his electronic cigarette and he needed to talk to the social worker. Some of the nurses were giving him a hard time. They did not help him enough. It made him frustrated. He was angry with the nurses. The consultations for treatment included nursing staff and the social worker. The Psychiatric NP note, dated 9/25/23 at 6:20 a.m., indicated the resident reported he was frustrated and felt like staff did not give him enough breathing treatments. He did not have a good appetite. He was mad at himself. He was a little depressed. He had anxiety and could not do exercises anymore. Consultations for treatment included nursing staff and the social worker. The record lacked documentation of any psychosocial follow-up with the Social Worker on the resident's concerns and mood changes. During an interview on 12/13/23 at 1:22 p.m., the SSD she was aware the resident had concerns about his cigarette pods. The psychiatric NP spoke with her directly about any concerns she felt were pertinent, but she didn't recall her reporting concerns about his breathing treatments, but that wasn't something that was normally brought to her. She did not document about following up on the resident's concerns			

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	about his electronic cigarettes. During an interview on 12/13/23 at 1:45 p.m., the DON indicated the SSD rounded with the psychiatric nurse practitioner and would come to nursing staff to report any concerns voiced. 4. During an interview on 12/11/23 at 10:22 a.m., Resident 115 was very tearful. She indicated she had to come to the facility because she lost her home and her care. She came here for therapy after a recent hospital stay. She was supposed to leave but didn't have anywhere to go, so they moved her upstairs. Social Services had not discussed with her any goals or where to go from here. The record for Resident 115 was reviewed on 12/11/23 at 11:30 a.m. The diagnoses included, but were not limited to, depression, HIV (human immunodeficiency virus), and mood disorder. The Admission MDS assessment, dated 11/23/23, indicated the resident was cognitively intact. The admission observation., dated 11/17/23 at 11:03 a.m., indicated the resident reported often feeling sad, depressed, or lonely. She had a serious mental illness. She felt down, depressed, or hopeless 12 to 14 days out of the last two weeks. She felt bad about herself or like she was a failure to herself or others 12 to 14 days out of the last two weeks. She planned for short term placement at the facility. A care plan was in place to monitor for signs of depression and mood swings. The care plan, dated 12/11/23, indicated the resident was at risk for fluctuations in mood. The interventions included, but were not limited to, allow resident to vent her feelings/frustrations,			

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	offer resident diversional activity such as listening to country music, provide resident with calm environment, give resident personal space, and psychiatric services as needed or routine. The nurse's note, dated 11/17/23 at 11:58 a.m., indicated the resident was admitted to the facility and all department heads were notified of her arrival. The Social Services note, dated 11/24/23 at 12:46 p.m., indicated the resident was requesting discharge in fear of a room move. The SSD assured her she would not be moving as long as she planned to remain rehabilitation to home. The resident informed the SSD she could not go home with her family member and would have to move in with a different family member. The SSD attempted to contact the family to confirm a discharge plan but got no answer. She advised the patient she would not be discharged until the SSD could confirm she had a place to discharge to. The Social Services note, dated 12/4/23 at 2:44 p.m., indicated the discharge date was received from therapy. The resident indicated she had nowhere to go. A list of housing resources was provided for disabled or senior individuals. The SSD was unable to provide any further resources as the patients income was zero. The patient said she did not have any family who could house her until she was able to obtain a livable income. The SSD and BOM (Business Office Manager) offered Medicaid and the resident did not want to apply. She said she would leave the facility. The resident would discharge to a homeless shelter on 12/5/23. The late entry nurse's note, authored on 12/14/23 at 10:59 a.m. and dated 12/6/23, indicated the ED			

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	(Executive Director), DON (Director of Nursing), and BOM (Business Office Manager) met with the resident and her family and friend. The SSD had met with them earlier and the family had been aggressive. The SSD had directed the family and friend to meet with the ED, DON, and BOM. During the meeting the family refused to take the resident home with them due to her diagnosis. They were educated on transmission however still refused to take her home. The family became argumentative and the resident requested they be removed from the meeting. The resident informed the DON, ED, and BOM of her desire to stay and file for Medicaid and housing. She was offered a long term care room and moved to the second floor. The record lacked documentation of any further psychosocial follow-up by the SSD or any social services staff in relation to her. During an interview on 12/13/23 at 1:15 p.m., the SSD indicated the resident had a recent diagnosis and had come to the facility for therapy. She was then discharged from therapy. The found out at discharge she wasn't able to return to her prior living situation. They completed a Medicaid application and kept her at the facility. The resident should get approval rather quickly due to an expedited diagnosis. She was inappropriate for assisted living because she was so young and did not have income. She gave the resident resources for housing based on her income which she would have to call and ask about. The resident was very capable of doing that herself. She could only assist with placement with assisted living. They tried not to discharge to homeless shelters. During an interview on 12/14/23 at 1:40 p.m., Resident 115 indicated someone spoke to her on			

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	12/13/23 asking if she was ok but she did not know who it was. Prior to then no one had stopped in to check on her aside from nursing staff. She did not know who the SSD was. She could not recall anyone giving her a copy of low income housing options. A family member had taken her to sign up for disability. On 12/4/23 she was told she could go to a homeless shelter, but she didn't want to do that. Somehow the facility came up with a way for her to stay there, they had not provided her any assistance or discussed long term care options with her aside from staying at the facility. She did not want to stay long term at the facility. She wanted to get her own apartment or go back home. The resident was very tearful during the conversation. During an interview on 12/14/23 at 1:55 p.m., CNA 23 indicated Resident 115 had only been there a week or two. She was crying a day or two prior. She was sad. She didn't like taking so many medications, she missed her family. She tried to talk to her and reassure her. She told her to call her family and tell them to come up and talk to her. She didn't know about the resident's personal family dynamics. She knew she was basically there because she was homeless. The Social Services Director Job Description, which was signed and dated by the SSD on 8/10/22, included, but was not limited to, "... The Social Service Director provides medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, and shares a responsibility towards creating and sustaining an environment that humanizes and individualizes each residents living area... Essential Position functions... Reviews resident's needs and care plan with progress notes indicating			

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	implementation of methods to respond to identified needs. Provides assistance to residents and spouses to utilize community resources through referral when the services needed are not provided by the facility. Provides assistance to residents in adjusting to the facility... Advises appropriate referrals to minimize social and economic obstacles to discharge. Coordinates discharge planning and communicates to those who need to know any obstacles the resident may have upon discharge..." 3.1-34(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.			

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	§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, record review and interview, the facility failed to ensure accurate documentation in the Controlled Drug Administration Record sheets of the administered narcotics for 3 of 56 residents receiving narcotics (Residents 64, 95, 20, 226, and 87) and failed to ensure oral and intravenous antibiotics were available for administration. (Resident 68) Findings include: 1. The following was observed on 12/12/23 at 1:57 p.m., in the 2 Southeast Hall medication carts 1 and 2: a. Resident 64's hydrocodone-acetaminophen 5-325 mg (milligram) Controlled Substances Record sheet had a count of 26 tablets left. The last dose was signed out at 6:30 a.m., by LPN (Licensed Practical Nurse) 13. There were 25 tablet of the medication on the card. The record for Resident 64 was reviewed on 12/13/23 at 2:30 p.m. The diagnosis included, but was not limited to, fibromyalgia. The care plan, dated 11/19/21, indicated the resident was at risk for pain related to decreased mobility, fibromyalgia, chronic back pain, and recent heart surgery. The interventions, included	F 0755	**F – 755 Pharmacy Services** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** Resident 64, 95 and 20 received their medications as ordered and the narcotic counts were documented by the end of shift. Residents 226 and 87 did not receive their medication and a medication error report and pain assessment was completed on both with no complaints of pain noted. NP and family were notified and the nurse responsible was educated on medication administration procedure and completed a medication administration skills validation prior to working next scheduled shift. Resident 68 missed 2 doses of an IV Antibiotic on 3/26/23, progress note indicates NP and pharmacy were notified and the IV doses were continued until 4/21/23. Resident 68 did not receive 3 doses of Gabapentin on 12/8/23. On 12/11/23 a	01/05/2024

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	but was not limited to, administer medication as ordered. The physician's order, dated 9/26/23, indicated to administer hydrocodone-acetaminophen 5-325 mg (milligrams) every 6 hours as needed for chronic pain. The Significant Change MDS (Minimum Data Set) assessment, dated 10/3/23, indicated the resident was cognitively intact. b. Resident 95's Lacosamide 200 mg Controlled Substances Record sheet had a count of 29 tablets left. The last dose signed out was between 7:00 a.m. and 11:00 a.m. by LPN 11. There were 28 tablet of the medication on the card. The record for Resident 95 was reviewed on 12/13/23 at 2:45 p.m. The diagnosis included, but was not limited to, convulsions. The care plan, dated 2/21/23, indicated the resident was at risk for adverse side effects related to the use of anticonvulsant or antiseizure medication. The interventions, included but were not limited to, administer medications as ordered, observe for effectiveness. The physician's order, dated 7/23/23, indicated to administer lacosamide 200 mg twice daily. The Significant Change MDS assessment, dated 10/30/23, indicated the resident was severely impaired c. Resident 20's pregabalin 100 mg Controlled Substances Record sheet had a count of 21 tablets left. The last dose signed out was between 7:00 a.m. and 11:00 a.m. by LPN 11. There were 20		medication error report was completed; NP and family were notified with no new orders. The nurse responsible was educated on medication administration procedure and completed a medication administration skills validation. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. On 12/11/23, DNS/designee began in-servicing licensed and qualified nursing staff on controlled substance policy in addition to completing a medication administration skills validation to ensure proper medication administration and documentation processes are followed. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DNS/designee will complete a narcotic count audit daily on all medication carts to ensure all narcotic medications are administered and documented as ordered. If there are any inaccuracies noted, the resident, NP and family will be notified, and the nurse will be given additional education and or appropriate	

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	tablet of the medication on the card. The record for Resident 20 was reviewed on 12/13/23 at 2:57 p.m. The diagnoses included, but were not limited to, pain in the knees and right hip, seizures, restless legs syndrome, and neuropathy. The care plan, dated 8/6/21, indicated the resident was at risk for adverse side effects related to the use of anticonvulsant or antiseizure medication. The interventions included, but were not limited to, administer medications as ordered, observe for effectiveness. The care plan, dated 8/6/21, indicated the resident was at risk for pain related to decreased mobility, chronic pain, and scoliosis. The interventions included, but was not limited to, administer medications as ordered. The physician's order, dated 8/26/22, indicated to administer pregabalin 100 mg, three times daily. The Annual MDS assessment, dated 9/13/23, indicated the resident was cognitively intact. During an interview on 12/12/23 at 1:59 p.m., LPN 11 indicated she would sign out narcotics when she gave them. She just got distracted by something or someone. 2. The following were observed on 12/12/23 at 2:20 p.m., in the 1 West medication cart: a. Resident 226's hydrocodone-acetaminophen 5-325 mg Controlled Substances Record sheet had a count of 20 tablets left. The last dose signed out was at 7:30 a.m. by RN 12. There were 21 tablets of the medication on the card.		disciplinary action. Additionally, DNS/designee will review administration compliance report daily using a medication errors audit tool. If there are any inaccuracies noted, the resident, NP and family will be notified, and the nurse will be given additional education and or appropriate disciplinary action. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** The DNS/designee will be responsible for the narcotic count audit tool and the medication errors audit tool daily times 4 weeks, weekly times 4, monthly times 3 then quarterly thereafter until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI Committed overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed. **5.** Date of compliance: 1/5/24	

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	The record for Resident 226 was reviewed on 12/12/23 at 3:00 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus with a foot ulcer, and cellulitis of the right lower limb. The physician's order, dated 12/11/23, indicated the administer hydrocodone-acetaminophen 5-325 mg every 4 hours as needed for pain. The care plan, dated 12/11/23, indicated the resident was at risk for pain related to coronary artery disease, status post coronary artery bypass graft, neuropathy, decreased mobility, and weakness. The interventions included, but were not limited to, administer medications as ordered, document effectiveness of medication, and notify the MD if pain was unrelieved and/or worsening. The resident was admitted on 12/10/23 and no cognitive status was documented. b. Resident 87's lorazepam 2 mg Controlled Substances Record sheet had a count of 4 tablets left. The last dose signed out was at 11:05 a.m. by RN 12. There were 5 tablets of the medication on the medication card. The record for Resident 87 was reviewed on 12/13/23 at 3:08 p.m. The diagnoses included, but were not limited to, somnolence, altered mental status, intellectual disabilities, and acute respiratory failure with hypoxia. The care plan, dated 10/31/23, indicated the resident was at risk for adverse side effects related to the use of psychotropic medication, antianxiety, antidepressant and hypnotic. The interventions included, but were not limited to, administer medications as ordered and observe for effectiveness.			

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The 5 Day MDS assessment, dated 11/5/23, indicated the resident was severely impaired.

The physician's order, dated 11/30/23, indicated to administer lorazepam 2 mg every 8 hours as needed for anxiety. The order was discontinued on 12/13/23.

During an interview on 12/12/23 at 2:27 p.m., RN 12 indicated she guessed it had been signed out, but not given.

3. The clinical record for Resident 68 was reviewed on 12/13/23 at 1:10 p.m. The diagnoses included, but were not limited to, osteomyelitis of the vertebra, lumbar region, type II diabetes, methicillin staphylococcus aureus infection, hemiplegia affecting the left side, dementia, repeated falls, and weakness.

The physician order, dated 10/23/23, indicated gabapentin 400 mg oral 4 time a day. Cefazolin 1 gram, IV (intravenous) every 8 hours, with a start date of 3/26/23.

The Significant Change MDS (Minimum Data Set) assessment, dated 10/22/23, indicated the resident cognitively intact.

The clinical record lacked documentation indicating why the medication was unavailable, physician notification and attempting to get the medication from a local pharmacy.

The MAR (Medication Administration Record), dated 12/8/23, indicated gabapentin 400 mg was not administered at 8:00 a.m., 12:00 p.m. and 4:00 p.m. due to the medication being unavailable at the pharmacy. Cefazolin 1 gram IV was not administered on 3/26/23, at 2:00 p.m. and 10:00

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	p.m. due to the medication was out of stock. During an interview on 12/13/23 at 12:08 p.m., the DON indicated if a medication was not available from the facility contracted pharmacy, they would go to a local pharmacy for the medication. The resident had been on long term antibiotics due to osteomyelitis of the spine. The infectious disease doctor was trying to keep the infection from spreading. Normally if a dose of antibiotics were not available the NP (Nurse Practitioner) would be called and she would change the stop date for the antibiotic, but the resident was on continuous antibiotics and the stop date could not be changed. During an interview on 12/14/23 at 10:30 a.m., RN 19 indicated if the pharmacy was unable to send the antibiotic they would check in the pix's system. Sometimes they had IV antibiotics. If they did not have any they would use the local pharmacy. During an interview on 12/13/23 at 1:20 p.m., the DON indicated she was unsure if the facility had a policy for documentation of narcotic administration. 3.1-25(b) 3.1-25(b)(3) 3.1-25(b)(8)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that			

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	conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on record review, observation and interview, the facility failed to ensure residents were served meals that conserved flavor, palatability and were at temperatures that were appetizing. This deficient practice had the potential to affect 116 residents currently residing in the facility. Findings include: 1. The review of the June to December 2023 Food Advisory Committee Meeting notes indicated the following concerns which were not addressed: - On October 5, 2023, the broccoli and cauliflower were so hard, as if it was not cooked. - On November 2, 2023, the food was not hot or cold enough. The Resident Council minutes for December 2022 to November 2023 indicated the following concerns: - On 12/27/22, the temperature of the food was not appropriate and the food was too cold or just room temperature. No follow up response to this concern. - On 1/25/23, the temperature of the food was not appropriate, and the meats were cold. - On 2/28/23, the temperature of the food was not appropriate, the salads were getting hot and were	F 0804	**F – 804 – Nutritive Value / Appear, Palatable / Prefer Temp** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** On 12/13/23, CDM checked all plate warmer bases to ensure proper heating function, 2 bases did not heat properly and were removed from service. On 12/15/23 CDM completed a dietary interview with residents 12, 115 and 13 to update residents' food preferences and completed a select menu to ensure the residents receive palatable, attractive, desired, and appetizing meals. On 12/13/23 the Maintenance Director locked out the sink on the second-floor pantry due to initial report concerning water taste from that source. Following repairs and testing the sink was put back in service on 12/29/23, Residents 12, 115 and 13 were offered a sample and all indicated the water was improved and did not have any unusual taste. **2: How other residents having the potential to be affected by**	01/05/2024

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	wilted due to them being put on the hot plate. - On 4/25/23, food was lacking seasoning, flavorings and spices. No follow up response to this concern. - On 6/27/23, the temperature of the food was not appropriate, food was coming out cold. No follow up response to this concern. - On 8/29/23, the temperature of the food was not appropriate, weekend meals were coming out cold. No follow up response to this concern. - On 11/28/23, the temperature of the food was not appropriate and the food did not look or taste good. No follow up response to this concern. During a check of the food temperatures with Cook 7, on 12/10/23 between 11:32 a.m. and 12:15 p.m., the following were observed: - Cook 7 was observed to test the food temperatures from the side of the pans, which had a higher temperature degree. After checking the temperatures in the center of the pans, the temperatures were much lower and the food items were placed back into steamer or oven and re-checked a short time later. The cook was not observed to have stirred the food to evenly distribute the heat. - The Brussels sprouts on the steam table originally had a temperature of 50 degrees Fahrenheit (F), the butter was sitting on top of the Brussels spouts and had not melted. The Cook took them off the steam table and placed the pan on the stove to cook. A re-check of the temperature at 12:10 p.m. indicated it was now at 201 degrees F.		**the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. On 12/20/23 CDM began educating all culinary staff on general food preparation and handling, food temperature and recording temperatures policies to ensure all residents receive palatable, attractive, and appetizing food. On 12/27/23, maintenance installed new shut off valves, supply lines and faucet. On 12/29/23, Culligan Water performed a water test with no contaminants noted in the test, residents received samples, no concerns noted, sink put back in service. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** On 12/26/23, CDM/designee began conducting tray line observation audits, recipe compliance audits and temperature monitoring audits daily to ensure compliance with facility policies. If there are any inaccuracies noted the employee responsible will be given additional education and or appropriate disciplinary action. ED to attend next resident council	

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	- The mashed potatoes on the steam table had a temperature of 131.7 degrees F. The Cook took them off the steam table and placed the large pan in the oven. A re-check of the temperature at 11:54 a.m. indicated the temperature was now at 135.7 degrees F. After being stirred, the Cook placed the potatoes into 2 smaller pans and placed them in the oven. A re-check of the temperature at 12:00 p.m. indicated the temperature was now at 167.7 degrees F. - The puree Brussels sprouts had a temperature of 164 degrees F. The cook put them back into the steamer. A re-check of the temperature at 11:52 a.m. indicated the temperature was now 167.7 degrees F. During the lunch observation on 12/10/23 between 11:32 a.m. and 1:15 p.m., the window from the dining room to the kitchen was observed open and a cool breeze was blowing through the window across the open pans of food on the steam table. The Temperature Log lacked documentation of a record of the meal having been temperature checked throughout the meal. During an interview with the Dietary Manager on 12/10/23 at 1:00 p.m., she indicated that the reason fish sticks would not be served on tonight's supper meal was because she only had one box of fish sticks. During a test of the temperature of the foods on the steam table and the oven on 12/11/23 between 11:35 a.m. and 12:00 p.m., the following were observed:		meeting with permission to inquire about the palpability and temperature of the food and the taste of water. If concerns are expressed appropriate follow up will occur and follow up with the residents will be completed **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** The CDM/designee will be responsible for the tray line observation audits, recipe compliance audits and temperature monitoring audit tools daily times 4 weeks, weekly times 3 months, then monthly times 6 months until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI Committed overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed. **5.** Date of compliance: 1/5/23	

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	- The pan of oven roasted potatoes was taken out of the oven and initially had a temperature of 130.1 degrees F. The Cook put the pan back into the oven. A re-check of the temperature of the potatoes after being removed from the oven at 12:00 p.m. was 178 degrees F. The cook was not observed to stir any of the food to evenly distribute the heat. The Temperature Log lacked documentation of the record of the meal having been temperature checked throughout the meal. A test tray was obtain from the 2 West food cart (the last cart to be served) after all the trays had been served. A check of the temperature of the foods at 1:08 p.m. with the Dietary Manager indicated the following: - Oven breaded chicken had a temperature of 114 degrees F. - Oven roasted potatoes had a temperature of 114 degrees F. - The green beans had a temperature of 117 degrees F. - The pineapple had a temperature of 53 degrees F. - The pellet hot plate base under the plate of food was cold to the touch. The Dietary Manager indicated at that time the temperatures were lower than they should have been and that the pineapples were just dipped up out of the can as the staff forgot about them. During an interview with the Dietary Manager at 1:30 p.m., she indicated they did use the pellet system to heat up their bottom plate holders to keep the food warm. When informed the pellet plate holder on the test tray was cold to the touch			

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	and was not observed to have been in use at lunch on 12/10/23. During the Resident council meeting on 12/12/23 between 2:00 and 2:40 p.m., the following concerns were indicated: - The food was cold frequently - no particular meal was more of a problem than others. Some of the aides would heat it up and some wouldn't. - The kitchen would also run out of food - they would respond that they had nothing left if asked. Residents had menus to circle to indicate what they wanted, but then they didn't get it because the kitchen would say they ran out. The residents also do not always get an alternate if they asked - the kitchen would tell them they didn't have it. During an interview with the Dietary Manager on 12/12/23 at 2:45 p.m., she indicated the reason the trays to second floor were late was because they had to stop serving the chili after the dining room was served around 12:30 p.m. because the chili needed to be brought back up to temperature as it had cooled off too much. She indicated the air was blowing through the serving window and doors were being opened frequently as she had also received her food delivery at the time of serving, but indicated the trays were not really that late to the units. When informed that at 1:53 p.m., the trays on West hall were just now beginning to be passed, she indicated she did not realize they were that late. While the Cook 8 was checking the temperature of the steam table items on 12/13/23 at 11:48 a.m., the window roll screen was observed up all the way. A cool breeze was steadily blowing through the window across the steam table food items as the			

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	lids had been removed. During an interview with the Cook 8 on 12/13/23 at 11:57 a.m., she indicated that normally the window roll was closed until it was time to serve the dining room. It was then opened to serve the dining room and then re-closed to finish serving the hall trays, but for some reason, it was opened early today. When the air was blowing across the food on the steam table, this could be a reason why the temperature of the foods might drop while serving. They were having trouble with the plate warmers as they might be getting old. At 12:51 p.m., the window roll was closed. During an interview with the Dietary Manager on 12/13/23 at 11:56 a.m., she indicated she had removed a couple of the heated bases because they were not working to keep the food hot. Cross Reference F565 and F809 2. During an observation on 12/11/23 at 1:14 p.m. a test tray was provided. The green beans were lukewarm. The potatoes were cool to taste. The temperature of the chicken was room temperature, and the meat was very dry on the end of the breast and moderately dry in the middle. a. The record for Resident 12 was reviewed on 12/12/23 at 9:35 a.m. The Significant Change MDS assessment, dated 11/6/23, indicated the resident was cognitively intact. During an interview on 12/11/23 at 10:45 a.m., Resident 12 indicated she did not like the food. The resident's had talked to dietary staff several times and they didn't feel like they were doing anything. There was no flavor too it. The food			

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	was horrible. The grilled cheese sandwiches could be used as ammo because they were so hard. The hamburgers were burnt. The vegetables were overdone, and the soups often were watered down. b. The record for Resident 115 was reviewed on 12/11/23 at 11:30 a.m. The Admission MDS assessment, dated 11/23/23, indicated the resident was cognitively intact. During an interview on 12/11/23 at 10:27 a.m., Resident 115 indicated the food was not good. It was cold by the time they got it. The pancakes that morning were undercooked. The sausage was always cold. One night they had lasagna, and it was burnt. It was just not good food. c. The record for Resident 13 was reviewed on 12/11/23 at 11:07 a.m. The Quarterly MDS assessment, dated 10/23/23, indicated the resident was cognitively intact. During an interview on 12/11/23 at 10:01 a.m., Resident 13 indicated the food was hit and miss, but when it was bad it was really bad, which happened 3 to 4 times weekly. It was often overcooked. The burgers were burnt and too tough. 3. During an observation on 12/13/23 at 9:26 a.m., CNA 22 filled a plastic cup with ice from the ice machine in the second-floor pantry. She then filled the cup with water from the pantry sink. She indicated this was where they obtained the ice and water for their residents. The water did have a taste and smell of mildew or mold.			

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	During an observation on 12/13/23 at 9:32 a.m., the Dietary Manager assisted with obtaining a pitcher of ice water from the second-floor pantry. The Dietary Manager tasted the water and indicated it tasted bitter, maybe not filtered, and that it didn't taste good to her. a. The record for Resident 12 was reviewed on 12/12/23 at 9:35 a.m. The Significant Change MDS assessment, dated 11/6/23, indicated the resident was cognitively intact. During an interview on 12/11/23 at 10:43 a.m., Resident 12 indicated the water tasted like mold and it stunk. It did not matter what cup it was given in, it smelled. They had told everyone, but nothing was fixed. b. The record for Resident 115 was reviewed on 12/11/23 at 11:30 a.m. The Admission MDS assessment, dated 11/23/23, indicated the resident was cognitively intact. During an interview on 12/14/23 at 1:40 p.m., Resident 115 indicated she didn't drink the water because it didn't taste right. It did not taste like water. It tasted like it was rusty. The facility's current policy titled Food Temperatures included, but was not limited to, "Policy: The facility will maintain proper food temperature control to prevent food borne illness. Procedure:...2. All hot and cold food items will be served to the resident at a temperature that is considered palatable at the time the resident receives the food...4. Cooking temperatures must be reached and maintained according to current			

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	FDA [Food and Drug Administration] Food Code guidance...6. To take hot food temperatures, insert the thermometer into the thickest portion of the food while avoiding bones, if present...7. To take cold food temperatures, insert the thermometer into the food item using care not to touch the container....8. Temperatures shall be monitored and recorded on the Weekly Temperature Record prior to the start of and throughout meal service to ensure holding temperatures are maintained....9. Hot foods will be held at or above 135 degrees F. If minimum temperature requirements are not maintained, food will need to be reheated to a minimum temperature of 165 degrees F for 15 seconds before serving..." 3.1-21(a)(1) 3.1-21(a)(2)			
F 0809 SS=E Bldg. 00	483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to			

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	residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. Based on record review and interview, the facility failed to ensure meals were served at the designated times and residents were offered a nourishing snack at night. This deficient practice had the potential to affect 116 of 116 residents currently residing in the facility. Findings include: Review of the June to November 2023 Food Advisory Committee meetings identified the following concerns: - On September 21, 2023, the residents were not getting snacks at night as staff were heard to say they were taking them home to their children. - On October 5, 2023, the snacks were not passed out until around midnight. - On November 16, 2023, dinner comes out late more often than not. During an interview with the Director of Health Services (DHS) on 12/10/23 at 1:33 p.m., she indicated dietary had stopped stocking the pantry with snacks because it was either not being passed or the staff were eating the food. A nourishment cart came out at 10:00 a.m., 2:00 p.m., and at night before dietary left for the evening with a variety of snacks to be passed to whoever wanted something. While walking to the Activities room on 12/12/23 at 1:53 p.m., the 2 West Hall trays were observed were just starting to be served. Upon questioning	F 0809	**F – 809 – Frequency of Meals – Snacks at Bedtime** **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were noted to have been affected by the alleged deficient practice. Meals are now being served timely within designated time parameters. All Residents are being offered snacks during evening shifts. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. On 12/18/23 ED, CDM and IDT discussed meal delivery times. It was determined the dining room should be served first to promote resident attendance and timeliness of meal cart delivery. Mealtimes were adjusted, proposed to the residents in the resident council meeting on 12/26/23. Residents agreed to the mealtime change, staff notification began on 12/27/23, time postings were changed on each unit and the mealtime change was initiated	01/05/2024

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	at this time, the Scheduler confirmed that they were just starting to pass trays to the residents on that hall. The trays were not always this late and that dietary offered no reason for them being late. During the December 12, 2023 Resident Council meeting, between 2:00 and 2:40 p.m., with 11 residents identified as being alert and oriented by the Activity Director, the following concerns were identified: - 4 of the 11 residents indicated they were diabetics and that the CNAs (Certified Nurse Aides) were not always coming around and offering a bedtime snack. Even if a resident asked for one, staff would not get them one as they would indicate the requested item was not available. One resident indicated that if residents did not eat their dinner meal, a snack was needed to hold them over until breakfast the next day and that was a long time to go without something to eat between lunch and breakfast the next day. - Evening meal tended to get to the floor by 6:30 p.m. to 7:00 p.m., sometimes it had been 8:00 p.m.., and residents were never told why it was late, which happened frequently. - The lunch trays today never came to the 2nd floor until 1:40 p.m. West hall was always served last. One resident indicated he had just received his lunch tray right before the Resident Council meeting today and did not have time to eat. The dining room was served by 12:30 p.m. and then 2nd floor was supposed to receive their trays shortly afterwards. During an interview with the Dietary Manager on 12/12/23 at 2:45 p.m., she indicated the reason the trays to second floor were late was because they		on 12/28/23. On 12/18/23, All staff education began on facilities snack management process to ensure residents routinely receive evening snacks. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** On 12/28/22, CDM/designee began conducting tray line observation audits daily for each meal to ensure timely meal delivery. If the mealtime is delayed, residents will receive notification to include reason why. On 12/28/23, ED / Designee began daily monitoring of HS snack delivery compliance using an HS snack audit to ensure residents are routinely receiving HS snacks. Each resident will be asked daily by SED / designee if resident was offered / received a snack in the evening. Any residents found to have not received a snack will be assisted with completing a snack preference sheet to ensure snack preparation and delivery of snacks to the resident. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** The SED / Designee will be	

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	had to stop serving the chili after the dining room was served around 12:30 p.m. because the chili needed to be brought back up to temperature as it had cooled off too much. She indicated air was blowing into the serving window and doors were being opened frequently as she had also received her food delivery at the time of serving, but indicated the trays were not really that late to the units. When informed that at 1:53 p.m., the trays on West hall were just now beginning to be passed, she indicated she did not realize they were that late. Observation of the lunch meal tray pass, on 12/13/23, indicated the trays were delivered to the units and dining room at the following times: - The Moving forward cart left the kitchen at 12:17 p.m. - The 1 West Hall cart left the kitchen at 12:24 p.m. - The Dining room served between 12:25 and 12:51 p.m. - The 2 East Hall cart left the kitchen at 1:06 p.m. - The 2 South East Hall cart left the kitchen at 1:20 p.m. - The 2 South Hall cart left the kitchen at 1:30 p.m. - The 2 West Hall cart left the kitchen at 1:41 p.m. The last tray was served by 1:44 p.m. The posted unit and dining room times indicated the lunch and dinner trays were to be served at the following times: - Moving Forward - 12:00 p.m. and 5:00 p.m.		responsible for the completion of the HS snacks QAPI audit tool daily times 4 weeks, weekly times 3 months, monthly times 6 months until continued compliance is maintained for 2 consecutive quarters. The CDM/designee will be responsible for the completion of the tray line observation QAPI audit tools daily times 4 weeks, weekly times 3 months, monthly times 6 months until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI Committed overseen by the ED. If a threshold of 90% is not achieved, an action plan will be developed. **5.** Date of compliance: 1/5/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155203	A. BUILDING 00 B. WING	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HILLCREST VILLAGE	203 SPARKS AVE JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	- 1 West Hall - 12:15 p.m. and 5:10 p.m. - Dining Room - 12:15 to 12:45 p.m. and 5:10 to 5:30 p.m. - 2 East Hall - 12:50 p.m. and 5:40 p.m. - 2 South East Hall - 1:00 p.m. and 5:40 p.m. - 2 South Hall - 1:10 p.m. and 6:00 p.m. - 2 West Hall - 1:20 p.m. and 6:10 p.m. The facility's current policy titled Bedtime Snacks (H.S. Snacks) included, but was not limited to, "Policy: Every resident will be offered a bedtime snack (H.S.snack) as medically appropriate. Procedure: 1. Residents are offered a snack consistent with their prescribed diet order before retiring each evening...3. H.S. snacks must be offered and nursing staff will document on the Medication Administration Record (MAR/eMAR) as accepted (A), refused (R), or sleeping (S)." 3.1-21(e)			