STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155042	A. BUILDING 00 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE VINCENNES	3801 OLD BRUCEVILLE ROAD, BOX 136 VINCENNES, IN 47591

(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
F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 1/26/24. This visit included the PSR to the Investigation of Complaint IN00424807 completed on 1/26/24. Complaint IN00424807 - Corrected. Survey dates: March 19, 20, and 21, 2024 Facility number: 000016 Provider number: 155042 AIM number: 100291500 Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 5 Medicaid: 65 Other: 11 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 28, 2024.	F 0000		
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons			

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

Ashli Wesley | Administrator | 04/13/2024

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

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	and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation and interview, the facility failed to ensure each resident was treated with respect and dignity for 1 random observation. A	F 0550	F550 This Plan of Correction is the facility's credible allegation of	04/19/2024

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	staff member was observed speaking in an undignified manner and refused to let a resident use the telephone. (Anonymous Resident) Finding includes: During an observation on 3/20/24 at 9:13 A.M., LPN (Licensed Practical Nurse) 3 shouted in a loud, demanding tone, "[name of resident] we aren't doing this, you can't use the phone until 4:00 P.M. just stop, just stop. Did he say F---. He laid on the floor the other day and said F---, F---, F---." During an interview on 3/21/24 at 10:10 A.M., CNA (Certified Nurse Aide) 4 indicated the Anonymous Resident's family requested to be called everyday at 9:00 A.M., 4:00 P.M., and 7:00 P.M. During an interview on 3/21/24 at 11:00 A.M., the Administrator indicated that residents are allowed to use the phone at any time and staff should not use profanity. On 3/21/24 at 11:54 A.M., the Administrator provided a Resident Rights policy, dated 8/23/17 that indicated, "...These rights include the resident's right to:...Use a telephone..." On 3/21/24 at 11:54 A.M., the Administrator provided a Dignity policy, revised 4/23/18 that indicated, "The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality..." This deficiency was cited on 1/26/24. The facility failed to implement a systemic plan of correction		compliance. Preparation and/or execution of this plan of correction does not constitute admission agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All staff will be in-serviced on Resident Rights and Dignity. Resident was left anonymous by ISDH. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** Residents were interviewed about staff using inappropriate language. All staff will be in-serviced on Resident Rights and Dignity. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**	

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	to prevent recurrence. 3.1-3(t)		All staff will be in-serviced on Resident Rights, Dignity and appropriate language and conversations in presence of residents. All staff will be in-serviced annually and on an as needed basis. All new hires will be in-serviced during the orientation process. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The SSD/DON/Administrator/Designee will interview select residents regarding dignity, appropriate language and conversations in the presence of residents. This corrective will occur 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. Date of completion: 04/19/2024	

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F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on interview and record review, the facility failed to ensure residents with limited mobility received appropriate services and assistance to prevent further decrease in range of motion for 3 of 3 residents reviewed for the restorative nursing program. (Resident 7, Resident 29, Resident 24) Findings include: 1. On 3/19/24 at 12:14 P.M., a list of residents receiving restorative therapy was provided by the MDS Coordinator and indicated Resident 7 should have PROM (Passive Range of Motion) 6 times per week. On 3/21/24 at 12:30 P.M., Resident 7's clinical record was reviewed. Diagnoses include, but were not limited to, traumatic brain injury and	F 0688	F688 This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	04/19/2024

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	hemiplegia affecting right dominant side. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 2/22/24, indicated Resident 7 was cognitively intact, had impairment of both upper and both lower extremities, totally dependant on 2 staff for toileting, transfers, and bed mobility, and received restorative therapy. A current Hemiplegia-Right Side of Body Care plan, revised 11/22/19, included, but was not limited to, the following intervention: Range of motion (active or passive) with am/pm care daily, initiated 5/25/17 A current Nursing Restorative Program: PROM Care Plan, revised on 2/19/19, included, but was not limited to, the following interventions: Document minutes on restorative grid, initiated 2/19/19 The clinical record lacked documentation of restorative therapy being completed from 2/24/24 through 3/21/24. 2. On 3/19/24 at 12:14 P.M., a list of residents receiving restorative therapy was provided by the MDS Coordinator and indicated Resident 29 should have AROM (Active Range of Motion) 3 times per week. On 3/21/24 at 12:20 P.M., Resident 29's clinical record was reviewed. Diagnoses included heart failure, stroke, and Alzheimer's disease. The most recent Quarterly MDS Assessment, dated 11/25/23, indicated Resident 29's cognition was moderately impaired and was an extensive assist of 2 staff for bed mobility, transfer, toileting and received restorative therapy.		Resident's 7, 29 & 24 are now receiving restorative per orders. Educate nursing staff about the importance of documentation. Facility is hiring for position of a dedicated restorative CNA. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who receive restorative have the potential to be affected; no other residents were identified as affected by this alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Facility is hiring for position of a dedicated restorative CNA. DON/MDS will monitor restorative program to ensure CNAs are completing restorative duties until FT restorative CNA is hired. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:**	

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	A current Nursing Restorative Program : AROM, revised 10/25/23, included, but was not limited to the following intervention: Document minutes on restorative grid, initiated 10/25/23 The clinical record lacked documentation of restorative therapy being completed from 2/24/24 through 3/21/24. 3. On 3/19/24 at 12:14 P.M., a list of residents receiving restorative therapy was provided by the MDS Coordinator and indicated Resident 24 should have AROM and dressing/grooming 6 times per week. On 3/21/24 at 9:54 A.M., Resident 24's clinical record was reviewed. Diagnoses included, but were not limited to, paraplegia. The most recent Quarterly MDS Assessment, dated 12/14/23, indicated Resident 24 was cognitively intact and totally dependent on two staff for transfers and toileting, and an extensive assist of 2 staff for bed mobility. He received restorative therapy. A current Nursing Restorative Program: Dressing/Grooming, revised 4/18/23, included, but was not limited to, the following intervention: Document minutes in POC (plan of care), initiated 4/24/23 A current Nursing Restorative Program: PROM, revised 10/3/23, included, but was not limited to, the following intervention: Document minutes on restorative grid, initiated 10/3/23		DON/MDS/Designee will monitor the restorative program to ensure restorative is being completed with the residents. This will be monitored 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. Date of completion: 04/19/2024	

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	The clinical record lacked documentation of restorative therapy being completed from 2/24/24 through 3/21/24. During an interview on 3/20/24 at 8:04 A.M., Licensed Practical Nurse (LPN) 26 indicated the Certified Nurse Aides (CNA) were responsible for doing restorative therapy and wasn't sure if it was being done because of staffing shortages. During an interview on 3/21/24 at 11:12 A.M., CNA 40 indicated she wasn't sure where to document the restorative therapy being completed since the new company took over around 3/7/24. During an interview on 3/21/24 at 11:07 A.M., the MDS Coordinator indicated she was in charge of monitoring the restorative therapy program but she wasn't sure where the aides were documenting it being completed because it's not in the CNA charting like it used to be. On 3/21/24 at 11:54 A.M., a current Restorative Nursing Program Policy, revised 1/4/19, was provided by the Administrator and indicated " Purpose: to promote each resident's ability to maintain or regain the highest degree of independence as safely as possible ... Each resident involved in a restorative program will have an individualized program with individualized program with individualized goals and measurable objectives documented on the plan of care. Documentation of the interventions and the resident's response will be completed with each implementation ... " This deficiency was cited on 1/26/24. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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	3.1-42(a)(2)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff was provided for 1 of 3 units reviewed. (A/B Unit) Findings include:	F 0725	F725 This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission agreement by provider of the truth	04/19/2024

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	1. During the survey dates of 3/19/24 through 3/21/24, the following anonymous staff interviews regarding A/B Unit were completed: a. There have not been any changes to staffing and we can't do it all. b. There needs to be more help on this unit. It is not safe and something is going to happen. c. "So the other 2 [residents] are in bed...[we] only can do what you can do...that's right especially with all the 2 assists...and the 2 Hoyers [lift]." d. There was not enough staff on this unit for the clientele. We have lost a lot of good staff because they got tired of working so short staffed. e. It was hard to get everything done with little help. Showers are not able to get done until hours later and often have to stay after the scheduled shift to complete them due to lack of staff. Unable to do any charting during the shift so staff had to stay after the shift to complete the charting. Working up to 16 hours a day to complete everything gets hard and the facility lost a lot of good staff due to not trying to get help. Several complaints had been relayed to staff from family members because they don't like how short staffed the unit is. f. There was only 1 nurse and 1 CNA (Certified Nurse Aide) which happened a lot. During an interview on 3/21/24 at 10:29 A.M., an Anonymous family member indicated her family was nervous when her family member came into the facility because the facility does not have enough help.		of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:¿¿ Facility reviewing nursing schedules and attempting to hire nursing staff as indicated to provide appropriate number of staff on all units including dementia care unit in attempts to ensure all residents needs are being appropriately met and resident supervision provided as needed. Facility has recently hired a Director of Nursing and a scheduler for nursing. is also using (agency) in the interim of hiring nursing staff. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Facility continues to educate and hire new staff. Nursing reviewed and adjusted daily and as needed to ensure residents' needs are appropriately met. How the corrective	

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	2. During an observation on 3/19/24 at 11:24 A.M., the A Unit had 1 nurse and 1 CNA. The B Unit had 1 nurse and 1 CNA. During an observation on 3/20/24 at 6:56 A.M., the A Unit did not have any staff on the unit. The B Unit had 1 nurse and 1 CNA. During an observation on 3/21/24 at 10:01 A.M., the A Unit had 1 nurse and 1 CNA on the Unit. The B unit had 1 environmental aide that could help pass ice and answer call lights, but could not provide care. 3. On 3/21/24 at 10:10 A.M., the A/B Unit was observed with 23 residents. There were two residents that required a full body lift for transfers, and 8 total residents that required assistance of 2 staff for activities of daily living. On 3/21/24 at 12:37 P.M., the Administrator indicated the facility does not have a policy related to staffing. At that time, she indicated she would like 2 nurses on the A/B Unit at all times and 2 to 3 CNA's. This deficiency was cited on 1/26/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-17(a)		action(s) will be monitored to ensure the deficient practice will not recur: DON/ADON/Designee will monitor progress to ensure compliance and appropriate measures are in place 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. Date of completion: 04/19/2024	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of			

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	communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to provide a sanitary environment to help prevent the development and transmission of diseases and infections in 1 of 2 residents reviewed for incontinence care and 2 of 6 observations of medication administration. Staff did not wear gloves when administering insulin. A medication was dropped on the medication cart, picked up, and administered to a resident. Staff wore the same gloves to perform incontinence care and then wipe the resident's face. (Resident E, Resident 4) Findings include: 1. During an observation on 3/19/24 at 11:44 A.M.,	F 0880	F880 This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. What corrective action(s) will be accomplished for those residents	04/19/2024

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	155042	A. BUILDING 00 B. WING	03/21/2024

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	CNA (Certified Nurse Aide) 5 provided incontinence care on Resident E. CNA 5 used 3 wash cloths to clean up a bowel movement. CNA 5 failed to remove gloves and grabbed a wash cloth off the night stand and cleaned Resident E's face and placed a clean brief under the resident. At that time, Registered Nurse (RN 6) indicated, "after care we change gloves," and CNA 5 indicated, "yes." CNA 5 removed her gloves after she placed the clean brief on and failed to sanitize or wash hands after donning new gloves. During an interview on 3/21/24 at 10:24 A.M., CNA 4 indicated that gloves should be changed between dirty and clean tasks and hand washing should be performed by singing the ABC song 2 times when dirty gloves are removed. 2. On 3/20/24 at 7:22 A.M., Licensed Practical Nurse (LPN) 3 prepared Resident E's medications. She sanitized her hands, popped three of her medications out of the packages into a medication cup. The fourth medication was dropped onto the top of the medication cart. LPN 3 donned a glove and picked the medication up and put it into the same medication cup as the other three medications and proceeded with preparing the rest of Resident E's medications. LPN 3 entered Resident E's room and administered all medications to the resident. 3. On 3/20/24 at 7:50 A.M., LPN 26 was observed administering insulin to Resident 4. After checking the orders for Resident 4, LPN 26 indicated Resident 4 needed 2 units of insulin for her blood sugar of 162. She grabbed the insulin vial in a bottle from the medication cart, removed the cap of the bottle, wiped the top of the insulin vial and drew up 2 units of insulin. LPN 26 went into Resident 4's room. LPN 26 wiped Resident 4's left arm with alcohol and injected the 2 units of		found to have been affected by the deficient practice:¿¿ Nursing staff educated on handwashing procedures, proper glove use, glove donning and doffing, glove use during insulin administration and medication administrator policy and procedures. Nursing staff will demonstrate appropriate infection prevention and control practices as per regulations. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected. Nursing staff educated on handwashing procedures, proper glove use, glove donning and doffing, glove use during insulin administration and medication administrator policy and procedures. Nursing staff will demonstrate appropriate infection prevention and control practices as per regulations. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Infection control and prevention in-servicing will be done annually and as needed. All new hires will receive in-servicing during the orientation process on infection control and prevention. How the corrective action(s) will be monitored to ensure the deficient practice will	

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	insulin. LPN 26 failed to wear gloves when giving the resident her insulin injection. During an interview on 3/21/24 at 12:37 P.M., the Administrator indicated if a medication was dropped the medication cart, it should be destroyed and another one should be administered. During an interview on 3/21/24 at 11:10 A.M., the Infection Preventionist indicated gloves should be worn to administer insulin to a resident. On 3/21/24 at 11:54 A.M., a current Incontinence Care Policy, revised 1/16/18, was provided by the Administrator and indicated " ... Perform hand hygiene and put on non-sterile gloves ... soap one cloth at a time to wash genitalia using a clean part of the cloth for each swipe ... remove gloves and perform hand hygiene ... do not touch any clean surface while wearing soiled gloves " On 3/21/24 at 11:54 A.M., a current Glove Use Policy, revised 1/31/18, was provided by the Administrator and indicated " ... non-sterile gloves shall be worn for procedures involving ... resident care or procedures requiring a sense of touch or that require contact with blood or body fluids ... gloves used for contact shall be removed and discarded after contact with each person, fluid item, or surface ... Hand hygiene will be performed after removing gloves ... " This deficiency was cited on 1/26/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(b) 3.1-18(l)		not recur: Infection Preventionist/DON/designee will monitor progress to ensure compliance and appropriate measures are in place 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A progress report will be forwarded to the QAPI committee monthly for at least 6 months and the plan adjusted accordingly. Date of completion: 04/19/2024	

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F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a sanitary environment for resident rooms and halls. The interior walls, doors, and floors were scuffed, chipped and or soiled. The exterior of the building had paint peeled off the frame and window frames. (A wing, B wing, C wing, D wing, E wing, I wing) Findings include: During an observation on 3/21/24 from 10:10 A.M. through 10:30 A.M., the following was observed on the A and B Unit. 1. The B Hall shower room door and door frame were scuffed at the bottom, and the frame had missing paint and chipped wood. 2. The nurses station between A and B Hall was observed with scuffed walls, paint missing and chipped. 3. The B Hall hallway was observed with several chipped tiles throughout and part of the tile missing around a copper circle on the floor. 4. The B Hall common area was observed with scuffed walls. 5. The A Hall shower room had a wall that was scuffed in front of the shower at eye level. 6. The A Hall hallway was observed with black and discolored parts throughout, as well as dents	F 0921	F921 This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:¿¿ Units A, B, C, D, E & I all in the process of repairing and/ interior walls and door, scuffed/chipped and/or soiled floors. A & B station is in the process of being painted. B Hall hallway is in the process of having floor repaired and/or replaced d/t chipped tiles throughout and missing tile around	04/24/2024

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	in the floor. 7. The bathroom between Room 5 and Room 6 was observed with a brown and black substance around the base of the toilet. 8. During an observation on 3/21/24 at 12:40 P.M., the following was viewed on the outside of the building: a. A wing: 11 sets of 4 windows had paint peeled off on the bottom 3 sides of the frame that meets the roof had paint peeled off of the wood in multiple places 1 wooden trim above the door to enter that wing had wood trim and paint peeled off 7 sets of air conditioner units viewed that had paint peeled off and the trim around the top of the units was peeled off. b. B wing: 1 set of 2 windows with paint peeled off 11 sets of 4 windows had paint peeled off 2 sides of the frame that meets the roof had paint peeled off in multiple spots 12 sets of air conditioner units viewed with peeled paint and 1 unit was dented in c. C wing: 8 sets of 4 windows had paint peeled off 1 wooden trim above the door to enter that wing had wood trim and paint peeled off d. D wing: 8 sets of 4 windows had paint peeled off the bottom of the window frame 3 sides of the frame that meets the roof had paint peeled off of the wood in multiple places 1 wooden trim above the door to enter that wing		cooper circle on floor. A hall shower room is in the process of being repaired and/or replaced d/t scuff marks, black & discolored parts throughout and dents on the floor. between rooms 5 & 6 has been cleaned and disinfected and brown and black substance removed from base of toilet. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All staff in- on work order protocols. Maintenance and housekeeping staff in- on homelike environment and upkeep. Administrator, Maintenance Director and Housekeeping Director to make facility rounds to ensure ongoing compliance.	

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	had wood trim and paint peeled off e. E wing: 1 wooden trim above the door to enter that wing had wood trim and paint peeled off f. I wing: 5 sets of 4 windows with paint peeled off During an interview on 3/21/24 at 11:25 A.M., the Maintenance Supervisor indicated he did not have a written plan to fix the environment issues because of the chaos, and the outside would not be started until the weather warmed up. On 3/21/24 at 12:36 P.M., a current Homelike Environment Policy, revised April 2014, was provided by the Administrator and indicated "Residents are provided with a safe, clean, comfortable, and homelike environment ... " This deficiency was cited on 1/26/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(f)		How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Administrator/Maintenance Director/Housekeeping Director/Designee will monitor all the capital projects such as floors, painting of facility, are done in a timely manner in conjunction with corporate. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. Date of completion: 04/24/2024	
F 9999 Bldg. 00	16.2-7-3 STAFF TRAINING AND DEVELOPMENT PROGRAMS (a) Each facility shall provide in service training and shall require all staff working with	F 9999	F9999 This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not	04/19/2024

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	developmentally disabled residents to attend staff development programs concerning developmental disabilities. Written records of such training shall be kept in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide in service training for staff specific to the 6 residents diagnosed with an intellectual and or developmental disability. This state finding was not met: During an interview on 3/20/24 at 9:57 A.M., the Administrator indicated the facility failed to provide in services to staff related to the intellectual and or developmental disabilities. During an interview on 3/21/24 at 2:34 P.M., the Administrator indicated there was not a policy, but it is their policy to provide in services for staff related to their residents with an intellectual or developmental disability. This deficiency was cited on 1/26/24. The facility failed to implement a systemic plan of correction to prevent recurrence.		constitute admission agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Facility has enrolled SSD in QIDP course with Lacy Beyl on 4/17/2024. When SSD returns staff will be in-serviced on residents with intellectual and/or developmental disabilities. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected; no other residents were identified as affected by this alleged deficient practice. Facility has enrolled SSD in QIDP course with Lacy Beyl on 4/17/2024. When SSD returns staff will be in-serviced on residents with intellectual and/or developmental disabilities. **What measures will be put into place and what systemic**	

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			changes will be made to ensure that the deficient practice does not recur: SSD/designee will monitor on-going staff education as needed and on an annual basis. All new hires will be educated on residents with intellectual and/or developmental disabilities in the orientation process. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** In-servicing on residents with intellectual and/or developmental disabilities has been added to the facility required in-servicing material. Administrator/designee to monitor progress to ensure on-going compliance. Date of completion: 04/19/2024	