STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155270	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORE OF DALE	510 W MEDCALF ROAD DALE, IN 47523

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F 0000 Bldg. 00	This visit was for the Recertification and State Licensure survey. This visit resulted in an Extended Survey - Substandard Quality of Care - Immediate Jeopardy. This visit included the Investigation of Complaint IN00405616, IN00406234, IN00409283 and Complaint IN00412693. Complaint IN00405616 - No deficiencies related to the allegations are cited. Complaint IN00406234 - No deficiencies related to the allegations are cited. Complaint IN00409283 - No deficiencies related to the allegations are cited. Complaint IN00412693 - Federal/state deficiencies related to the allegations are cited at F600. Survey dates: July 24, 25, 26, 27, 28, 29, 30, 31, August 1, 2, 2023 Facility number: 000170 Provider number: 155270 AIM number: 100287490 Census Bed Type: SNF/NF: 41 Total: 41 Census Payor Type: Medicare: 0 Medicaid: 40	F 0000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The facility request's Paper Compliance for this survey.	

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

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	Other: 1 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 9, 2023.			
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at			

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	the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on observation, interview, and record review, the facility failed to clarify a Resident's code status for 1 of 1 residents reviewed for advanced directives. A Resident's current facesheet did not match physician orders or the signed "CHOICE OF TREATMENT" form. (Resident 3) Finding includes: During record review on 7/25/23 at 1:32 P.M., Resident 3's diagnoses included, but were not limited to non-traumatic brain dysfunction, seizure disorder, and psychotic disorder. Resident 3's chart had a full code sticker placed inside the front of the binder. A current facesheet indicated Resident 3's code status was CPR (cardiopulmonary resuscitation). A signed "CHOICE OF TREATMENT" form, dated 9/21/16, indicated "...I hereby request that [name of facility] PROVIDE COMFORT MEASURES ONLY care. I understand that Cardiopulmonary resuscitation (CPR) will not be performed by the staff if a life support situation	F 0578	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: The code status of Res# 3 was verified and entered consistently into all relevant locations within the medical record. 2. Identification of other residents having the potential to be affected was accomplished by: Determining the code status or presence/absence of Advance Directives is required for all residents. Therefore, all residents	09/18/2023

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	occurs..." Physician's orders included, but were not limited to, "CODE STATUS: DNR [do not resuscitate]," dated 4/9/18. A current advanced directives care plan, revised 6/24/23, indicated "Resident has the following Advance Directives on record: Do Not Resuscitate...Resident is not capable of making informed consent regarding their health care decisions..." During an interview on 7/27/23 at 11:10 A.M., RN (Registered Nurse) 15 indicated Resident 3 was a full code and she was unsure why the physician's order did not match. During an interview on 7/27/23 at 1:34 P.M., the DON (Director of Nursing) indicated Resident 3 was originally a DNR, but he did not have a current guardian or power of attorney to complete a POST (physicians orders for scope of treatment) form, therefore the facility changed his code status to CPR. On 7/31/23 at 1:30 P.M., the Administrator provided an undated Advance Directive Policy that indicated "...To provide services to our residents that will recognize and respect their dignity as individuals for freedom of choice related to healthcare...The copy of the Advance Directive will become a permanent part of the medical record..." 3.1-4(f)(5)		have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** The Director of Nursing Services educated social services and licensed nurses regarding the documentation procedures for Advance Directives/code status. A chart audit of all residents will be completed on 9/8/23. Discrepant findings will be addressed immediately, and all needed actions were completed by 9/18/23. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** For 6 months, the Director of Social Services or designee will perform weekly medical record audits of all new admissions and those residents on the MDS assessment schedule for consistent documentation of the resident's Advance Directive/code status throughout the medical record. After the initial 6 months, the Director of Social Services will complete a medical record audit for consistent documentation on all new admissions for 6 months. Results of the audits will be discussed monthly with the QA committee until such a time it is determined that substantial compliance is maintained. Corrective action completion date:	

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			9/18/23	
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility			

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	offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.			
	Based on interview and record review, the facility failed to provide required notices to residents being discharged from Medicare services for 1 of 3 residents reviewed. The SNF-ABN (Skilled Nursing Facility-Advanced Beneficiary Notification) and the NOMNC (Notice of Medicare Non-Coverage) was not provided to a resident who remained in the facility within the required time frame. (Resident 7) Finding includes: On at 7/24/23 at 1:00 P.M., Resident 7's discharge from Medicare services was reviewed. The facility/provider initiated Resident 7's discharge from Medicare Part A services when benefit days were not exhausted. Resident 7 was discharged from Medicare services on 4/13/23 and remained in the facility.	F 0582	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 7 - A NOMNC form was sent to the residents' representative for signature and a	09/09/2023

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	A SNFABN form dated 4/11/23, was signed as received by the resident's former guardian on 4/14/23. A NOMNC form with Resident 7's name and discharge date of 4/13/23 was not signed as received by the resident or representative. During an interview on 7/25/23 at 9:53 A.M., the Social Service Director indicated they did not know why the SNFABN form was not given to Resident 7's guardian prior to the Medicare service discharge date and was not sure why the NOMNC form was not signed. On 7/31/23 at 1:30 P.M., the facility administrator supplied a policy titled, Advanced Beneficiary Notices, dated 10/2022. The policy included, "...7. To ensure that the resident, or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided at least two days before the end of Medicare covered Part A stay... 8. The Social Service Director, or designee is responsible for issuing notices... 10. Delivery requirements: ...d. If the notice cannot be hand-delivered (for example, such as in the case of an incompetent resident and the representative is out of town), a telephone notice shall be made, followed up immediately with a mailed, emailed, faxed or hand-delivered notice. Documentation shall comply with form instructions regarding telephone notices..." 3.1-4(f)(2)		phone call was made and documented as to what happened. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that residents with a qualifying hospital stay and Medicare Part A benefit days available have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** An audit was conducted on current residents who were admitted in the past six months, and any corrective actions were completed on 9/8/23. The Administrator educated the following personnel on the facility's Advance Beneficiary Notices policy: Business Office Manager, Social Services Director, MDS Coordinator, Director of Nursing, Therapy Program Manager. Copies of the relevant forms were given at this time. These actions will be completed on 8/29/23. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Social Service Director/ designee conducted an audit on current residents who were admitted in the past six months, and any corrective actions will be completed on 9/8/23. The Social Service Director will audit any new admissions onto	

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			the Medicare Part A program to ensure that the ABN/NOMNC forms are completed/signed timely and/or documented that a call was made, and the forms was sent via mail/email to obtain signatures. The Administrator will follow up Social Services to ensure compliance with the program, with each Medicare Part A stay. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date: 9/8/23.	
F 0600 SS=J Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 0600	**F600 IDR this portion of F**	09/01/2023

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	A. Based on interview and record review, the facility failed to protect the resident's right to be free from neglect for 1 of 1 resident reviewed for discharge. A resident (Resident B) with a court order to remain at the facility was allowed to leave and did not return. The resident was being monitored for suicide precautions at the time the resident was allowed to leave with an unknown female and has never returned. The resident's whereabouts was currently unknown. Legal authorities and the physician were not notified of the resident's departure from the facility or failure to return. As an endangered adult, the resident has the potential of harming himself if not under supervision. The resident had a history of being aggressive which has the potential of others being harmed as well. (Resident B) B. Based on observation, interview, and record review. The facility failed to protect each resident from physical and verbal abuse for 2 of 3 residents reviewed for abuse. A staff member struck a resident on his chest when perineal care was being provided. (Resident C, Resident E) This Immediate Jeopardy began on July 4, 2023 when the facility failed to implement a court order to ensure Resident B was under 24-hour supervision and allowed the resident to leave the facility. When the resident called the following day to inform staff he was not returning, staff failed to notify the physician or the Adult Protective Services (APS) representative handling his case. The Administrator was notified of the Immediate Jeopardy on July 28, 2023 at 8:35 A.M. The Immediate Jeopardy was removed on July 31, 2023, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.		**600-A** **A.** **Immediate action taken for the resident found to have been affected include:** Resident B no longer resides at the facility. The court order was filed on May 8th for the duration of 60 business days and a court date was set for **July 20th, 2023**. The facility was not informed if the July 20th court date was continued or canceled. The facility will no longer admit a resident with a court order without a guardian to oversee the stay and make decisions on behalf of the resident. **Identification of other residents having the potential to be affected was accompanied by:** The facility has determined that no residents have the potential to be affected by this as no other residents have court orders in place. **Actions taken/systems put in place to reduce the risk of future occurrence include:** The facility will no longer admit a resident with a court order without a guardian in place to oversee the stay and make decisions on behalf of the resident. Staff was initially in-serviced on 7/28/23 and then ongoing, monthly, on the facility policy and procedures for elopement prevention and Abuse and Neglect.	

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	Finding includes: A. 1. On 7/26/23 at 8:42 A.M., Resident B's clinical record was reviewed. Admission date was 6/29/23. Diagnosis included, but were not limited to, borderline personality disorder, schizophrenia, diabetes mellitus, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD). On admission, Resident B was cognitively intact, alert and oriented to name, place, month, and time. A referral assessment tool form (not dated) indicated Resident B to be admitted from another long-term care facility. Resident B required assistance of one staff member for mobility and needed therapy. Handwritten notes included "Schizophrenia COPD Cirrhosis CHF ... refuses meds [at] times ... plays music very loud ... protective order from court to be in facility - cannot leave ... court order to be in NH [nursing home]. Goes back to court 7/20/23 - APS involved ... Wants to get out asap." Admission records from the previous facility included the following information: Resident B was his own responsible party with emergency contact information for the APS representative handling his case, a friend, and a sister (with name listed). A new admit form, dated 6/29/23, indicated "Will "make up things" about sister, family, APS etc. He will say it's "OK" to do this or that. He has a cell phone - be watchful that he does NOT take pictures of others. We can take away per court order if does."		IDT members will meet monthly to review at-risk residents for elopements to address any issues and/or needs for new plans for supervision of at-risk residents. Corrective actions will be taken as needed or as identified. **How the corrective actions will be monitored to ensure the practice will not reoccur:** The facility will no longer admit a resident with a court order without a guardian to oversee the stay and make decisions on behalf of the resident. The Administrator was educated by the Regional Director, regarding not accepting residents with a court order without a guardian to oversee the stay and make decisions on behalf of the resident. The Administrator educated the DON, ADON, and SSD regarding not accepting residents with court orders without a guardian to oversee the stay and make decisions on behalf of the resident. New referrals will be reviewed in morning meetings to determine the status of POA/Guardianship as well as if any court orders are in place. Review will be documented in morning meetings when referrals are presented. Staff will be in-service by the DON and SSD on the facility policy and procedures for elopement prevention, Abuse and Neglect, Therapeutic Leave of Absence	

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	A resident information sheet indicated Resident B was admitted 6/29/23 at 11:30 A.M., the APS representative was listed as emergency contact #1, and Resident B was his own person, no guardian or power of attorney (POA). A 48-hour care plan, dated 6/29/23, lacked information related to a court case, or APS. The care plan did not indicate that Resident B was to stay in the facility. A care plan, dated 6/30/23, indicated Resident B had potential to fabricate stories related to a sister and others. Physician orders included, but were not limited to, the following: LOA (leave of absence) with responsible party as needed, dated 6/30/23. Send to ER (emergency room) for psych evaluation and treatment, dated 7/2/23. A current court order, filed 5/8/23, indicated the following: "IN THE MATTER OF PROTECTIVE SERVICES FOR [RESIDENT B] ... That [Resident B] is an endangered adult as defined by I.C. 12-10-3-2 ...That [Resident B] is in need of the proposed emergency protective services ... IT IS NOW ORDERED, ADJUDGED, AND DECREED by the Court all as follows ... That the objectives of the Emergency Protective Order are to secure the safety and well Being and person of [Resident B] ... That the medical provider delivers the lease restrictive protective services necessary to attain the objective of the Adult Protective Services Protective Order. The medical provider shall place		Policy & Procedures as well as the addendum to the therapeutic policy, quarterly and ongoing. The Director of Nursing and/or Assistant will monitor presentations of in-service quarterly and will add to the new hire packet. The Director of Nursing and/or Assistant will present any noncompliance to the in-services at monthly Quality Assurance meetings. The facility added an addendum to the Therapeutic Leave policy if the facility should take a resident with a court order, stating: 1. Should a resident with a court order, such as, to" remain at the facility" is admitted and wants to take a leave of absence or wants to discharge, the facility will take steps to ensure that the resident remains in the facility by: a. Notifying the Poa, Guardian, Adult Protection Services and/or Court that the resident wishes to go on a leave of absence or discharge. b. The nurse will document the residents request to leave as well as the conversation with the appropriate person or entity notified. c. Resident will remain in the facility, per court order/APS guidelines or upon clarification of court order or guidelines. This plan of correction will be monitored at the monthly at-risk for elopement meetings as well as	

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	the endangered adult [Resident B] in a medical facility/nursing facility that specializes in geriatric psych if needed or recommended by physician with 24-hour care. Facility may restrict the use of cellular device at their discretion for the duration of sixty (60) business days or until the order is terminated by the petitioner ... The healthcare provider shall maintain custody of the endangered adult for a period of not less than sixty (60) business days unless the order is terminated by the petitioner ..." A report triage note, dated 7/2/23 and signed by the Nurse Practitioner (NP), indicated a request to have an order to send Resident B to the ER for evaluation and treatment. She indicated he was "off the chain and refuses all his meds". She indicated she was not aware of Resident B's admission and knew nothing about him. Staff did not notify her of his admission to the facility. Police had been called to "get a handle on him" because he was scaring the other residents. She indicated the Administrator was going to work on having him sent somewhere else that week. A history and physical form, dated 7/4/23, indicated "Patient seen today for admission to [name of facility] for continued care and rehab. He has been in and out of behavioral inpatient facilities, held on ED [emergency detention] holds several times, due to his schizophrenia that is often unmanaged. In addition to this dx [diagnosis], he also has medical conditions such as CHF, DM [diabetes mellitus], HTN [hypertension] that are often unmanaged as well due to not taking medications. He believes he is "healthy as an ox" and his medical records are incorrect. He went as far as to steal his medical record (MAR) this weekend and attempt to hide it from staff. He also became aggressive with staff,		the monthly Quality Assurance meetings. ADDENDUM: 7/29/23 Staff has been in-serviced by the DON and SSD on the facility policy and procedures for elopement prevention, Neglect, Therapeutic Leave of Absence Policy & Procedures as well as the addendum to the therapeutic policy, quarterly and ongoing. The Director of Nursing and/or Assistant will in-service agency staff, ongoing, as new staff are scheduled to work. A spreadsheet has been made to track which agency staff have been in-serviced. The in-service has also been added to the agency binders at the nurses' stations for reference. The Director of Nursing and/or Assistant will monitor presentations of in-service quarterly and will add to the new hire packet. The Director of Nursing and/or Assistant will present any noncompliance to the in-services at monthly Quality Assurance meetings. **INFORMAL DISPUTE RESOLUTION FOR F-600, part A** ***We respectfully dispute tag F-600, part A, and request that it be deleted or at a minimum, decrease the scope/severity and/or the number of days of noncompliance due to the following rationale:*** Resident B was admitted to Core	

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	yelling and cursing at staff and other. He was refusing medications and was sent to the ER. Police had to be called to get him to go with EMS [emergency medical services]. ER evaluated him and then sent him back with no new orders. He is under APS yet is still adamant that he is "his own person". Very high thoughts of himself, that he has "tons" of money and lots of resources. Told me several inaccurate accounts of what has transpired over the years to him. He is on a diabetic diet and 2000 ml [milliliter] fluid restriction. He currently has a tooth abscess and is on ATBs [antibiotics] for this. Recently went to dentist for this. He uses a walker and wc [wheelchair] for ambulation but states he can walk independently "just fine". SS [social services] is attempting to locate a behavioral health center to transfer him to as this is not the appropriate environment for him at this time. He needs more psych management than this facility will be able to provide ... He tells me that he is going to a family function this afternoon with his sibling. Unsure if this is a delusion or a correct statement. Staff is unsure as well. I have been able to locate his prior records in EPIC [electronic medical record system], although it is not comprehensive view given, he has been in numerous facilities over the years that are not part of that EHR [electronic health record] system or integrated onto it". The form indicated Resident B had a confused cognitive status and was signed by the NP. Progress notes included, but were not limited to, the following: 7/3/23 (no time listed) " ... Judge does not want him released to community. Resident risk to self and others. APS reported they are able to give consent for treatment and sign paperwork. Homeland security called D/T [due to] resident		of Dale on 6/29/2023. He came with a court order to remain in the facility, we are not disputing that fact of the matter. However, the court order did not state that he was not his own person, or that he had a guardian or Power of Attorney to make his decisions for him. The court order did not state he could or could not go on therapeutic leave with family members. The court order itself is very vague. Healthcare providers have been taught for many years and it's engrained in our minds that a person admitted to a nursing facility has rights. We live by resident rights daily in nursing homes. We ensure their rights are protected. State and federal regulations require nursing homes to have written policies covering the rights of residents. Any person requiring nursing home care should be able to enter any nursing home and receive appropriate care, be treated with courtesy, and enjoy continued civil and legal rights. **Indiana Admin. Code states in part:** 410 Ind. Admin. Code 16.2-3.1-3 (c) In the case of a resident adjudged incompetent under the laws of the state by a court of competent jurisdiction, the rights of the residents are exercised by the person appointed under state law to act on the resident's behalf.	

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	called SS [social security] office threatening to commit suicide if they didn't help him. They wanted to make sure he was not living [sic] or had access to leaving ... Resident was informed that APS is in charge and able to handle his affairs and can sign ... Primary notified d/t [due to] reports that he made threats to commit suicide ..." Resident B was currently on 15-minute checks. 7/3/23 (no time listed) "Received order for inpatient psych eval" 7/4/23 5:00 P.M. Resident's sister and brother-in-law picked resident up at 4:30 P.M. that day, signed by LPN 7. 7/5/23 (no time listed) Resident went LOA with a female who he reported was family on 7/4/23. Resident did not return. Administrator communicating with APS. Resident did call SSD to report he was okay and proceeded to report reasons why he left. "All a fabrication", signed by the SSD. On 7/28/23 at 9:25 A.M., a 15-minute check form was provided for Resident B. Checks began 7/3/23 at 11:30 A.M. and the last one was completed 7/4/23 at 4:30 P.M. A blank form was already filled out with the resident's name for 7/5/23. A sign out sheet indicating Resident B was signed out by a "person accepting responsibility" was dated 7/4/23. On 7/26/23 at 10:02 A.M., the Social Services Director (SSD) indicated she was aware of a court order that Resident B was supposed to be in a nursing home until his court date but did not know that date. She indicated he had a history of		Adult Protective Services had since November of 2022, to find and/or provide Resident B with a guardian, and more importantly, Resident B was NOT adjudicated incompetent by the courts; therefore, he made his own decisions and had the same rights as every other resident in the nursing home when he was admitted. Should the nurse have chosen to ignore Resident B's right (in a nursing home) to visitors and/or a therapeutic leave of absence, we would have been cited for this, by holding him here, even with the court order, because he was his own person. This was a “no win” situation the facility was in. The nurse chose Resident B’s right to therapeutic leave with his “family”. Of note, we do not do background checks on visitors who sign out resident’s, taking responsibility for them. The nurse had no way of knowing the persons who signed Resident B out, had criminal histories or even the fact if they were his family since he had just come to us a few days prior. The person who signed him out stated she was his sister and even showed her driver's license to the nurse, so the nurse had no reason to believe otherwise. **410 Ind. Admin. Code 16.2-3.1-3 states in part:** (1) Choose activities, schedules, and health care consistent with	

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	using his cell phone inappropriately and it could be taken if needed. The court order was included in all the other information given to staff when Resident first came to the facility, but there was nothing in the court order that said he could not leave the building and go LOA. APS told her that he was not supposed to be discharged to the community and needed to be in a long-term care facility. He did not have a wander guard. She indicated while here, Resident B displayed a lot of socially inappropriate behavior, blaring of music on his phone, verbal cursing of the staff, and refusing care. She indicated Resident B said that was how he was going to act, and he would not change his behavior. She indicated he was educated about his behavior and would apologize and then do it again. Other residents complained of his behavior. She indicated Resident B had gone to the ER on 7/2/23, and on his way back on 7/3/23, he called the social security office in (city name) and threatened to commit suicide in their office if they did not make him the payee of his social security. Because of the threat, Resident B was placed on a suicide watch when he returned to the facility, but the next day was a holiday and administrative staff were all off. She indicated nursing staff should have documented the suicide watches, and should not have let him leave while on the watches, as they were to remain in effect until an evaluation was completed by psych. She indicated she questioned that decision, but the nurse on duty thought the person that came was family, so she allowed him to leave. Upon her return to the facility on 7/5/23, she had an inpatient facility for him to be transferred to, but he was gone. On 7/26/23 at 10:15 A.M., the Administrator indicated the information provided from Resident B's previous facility included, but were not limited		his or her interests, assessments, and plans of care. (2) Interact with members of the community both inside and outside the facility. (3) Make choices about aspects of his or her life in the facility that are significant to the resident. Resident B had the right, while in the facility to: Individuals, services, community members, and activities inside and outside the facility, Visitors of his or her choosing, at any time, and the right to refuse visitors. He could also exercise civil and religious liberties, including the right to independent personal decisions and knowledge of available choices. He could refuse medication and treatment and discharge himself from the facility should he so choose, after being fully informed and understanding the probable and/or possible consequences of such actions. Resident B was informed, when he called on 7/5/23, to notify the facility he was not returning from his therapeutic leave, that he had a court order to be in the facility and he would be in contempt of court should he choose not to return. Resident B stated he knew, and he was going to the courthouse the following week to file a dismissal for the Adult Protective Services, he did not need to be in a nursing home, he wanted to live independently and	

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	to vaccine information, diagnosis information, medication information, and allergies. She was also notified that Resident B had behaviors of playing music very loud and had a court order to take his phone as needed. Resident B had an order to be in a facility and had no guardian or POA. On 7/28/23 at 7:53 A.M., Licensed Practical Nurse (LPN) 3 indicated if a resident expressed suicidal ideation she would document in the resident's chart as a behavior and report to the SSD. Staff should also notify the resident's family and physician. Staff should initiate 15-minute checks as an immediate intervention and document those checks on a form for at least 48-72 hours, possibly longer depending on if the resident continued with the suicidal comments or behaviors and may be placed on 1:1 supervision. She indicated staff should then implement whatever the physician or psych services ordered. The resident may be sent out for a psych evaluation. If a resident were on 15-minute checks due to suicidal ideation, staff should absolutely not allow them to go LOA without approval from the physician, administrator, etc. The following information was provided by confidential correspondence: The facility accepted Resident B from another long-term care facility. APS had a current order related to Resident B that he was not to leave the facility. APS was trying to find him a guardian due to a doctor deeming him incompetent. APS notified the facility of Resident B's court order and behaviors on 7/28/23 prior to admission, as well as Resident B would try anything to leave the facility. APS was assured by the facility there were other residents with mental health concerns		go to New York. Per unofficial court document printed from MyCase.gov: On 7/11/23, Resident B in fact, went to the Vanderburg County courthouse to file a motion to dismiss his case from Adult Protective Services. Then the following week on 7/20/23, the hearing for the continued APS Order was conducted and the order was dismissed due to not having jurisdiction. Resident B was more than capable of going to the courthouse on July 11th to file the motion to dismiss his case. Therefore, the Immediate Jeopardy that the IDOH cited for 28 days is unreasonable and unwarranted. We respectfully request this number of days to be reduced. Resident B called the facility again on 7/28/23 to say he would be coming soon to pick up his belongings after he secures transportation capable of hauling his items. He would call again to let us know when to expect him. The above facts show that Resident B was in no distress from health issues and there were no concerns for his safety. He was proving he was doing the right things by arranging suitable transportation for his belongings as well as taking the appropriate steps to dismiss his case. Respectfully submitted:	

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	and their staff could handle Resident B. It was made very clear that Resident B was not to leave the facility for any reason and the court order indicated he was to remain in a 24-hour facility. The facility indicated Resident B had already called them about a sister he wanted to visit with. The facility was then informed Resident B did have a sister, but they did not have contact with each other, and he could not leave the facility for any reason. It was requested that if Resident B wanted to visit with anyone, that they needed to come to the facility to see him. On 7/5/23, the APS office indicated Resident B had called them from a different state and had paid someone from a social media account to claim they were his sister and brother in law to come pick him up from the facility the day before. APS was not notified that Resident B was "missing" and failed to follow a court order signed by a judge. Resident B was in extreme danger to himself and others. The facility spoke with the APS office on 7/3/23 about looking into moving Resident B into another facility. The facility "did not want him as a resident" after only a few days related to his behaviors and manipulations which they had indicated prior they were equipped to handle. The court order for Resident B indicated he was to remain in a 24-hour facility, as when it was originally executed, Resident B was found on his floor unable to get up and was "hours from passing away". A welfare check was done to the individuals that came to pick up Resident B from the facility, but Resident B could not be located. Both individuals had a criminal record. A current non-dated missing resident action plan was provided 7/28/23 at 9:17 A.M. and indicated when a resident was missing, staff should notify police, the Director of Nursing (DON), family or		Lorri Maples, HFA **Core of Dale** --- --- **B.** 1. Immediate action(s) taken for the resident(s) found to have been affected include: A thorough investigation was conducted and completed by the Administrator and SSD regarding the allegations made by a resident concerning an agency aide's treatment of a resident. The abuse allegation was reported to ISDH at the time for residents C and E. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** In-service educations were conducted by the Director of Nursing, Administrator and SSD with all direct care and ancillary staff, addressing the facility policies and procedures regarding abuse and neglect, intervening and reporting, documentation of behaviors and importance of care planning, and safety. The Director of Nursing Services, or designee, has had agency personnel read and sign the	

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	responsible party, the physician, the facility Administrator, and the state agency. A current abuse policy, dated 9/15/17, was provided 7/28/23 at 7:45 A.M. and indicated "It is the policy of [facility name] to ensure that each resident is free of physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect and involuntary seclusion. [name of facility] prohibits the mistreatment, neglect, abuse of residents and misappropriation of residents' property by anyone including staff, other residents, or persons from outside the facility ... Neglect can also be ab [sic] action or lack of action that places one or more residents in a life-threatening situation." A current non-dated suicidal precautions policy was provided 7/26/23 at 10:04 A.M. and indicated "It is the policy of the facility to protect the rights of the residents but keep the resident safe. When a resident makes statements to cause harm to self or attempts to cause harm to self the resident must be immediately placed on precautions. At first the resident must be placed on 1:1 until the incident has been assessed and determined if the resident needs sent out." A current non-dated notification of change policy was provided 7/28/23 at 9:28 A.M. and indicated "The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification ... Circumstances requiring notification include ... A transfer or discharge of the resident from the facility" The Immediate Jeopardy, that began on 7/28/23,		Abuse and Neglect policy individually, upon coming to the facility to work, and given an opportunity to ask questions to ensure understanding. The signatures of all agency staff that have read and signed the policy will be kept on file for review. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing will audit the signature logs weekly, to ensure any agency personnel who worked that week, had a signed copy of understanding of our Abuse policy on file, until such time agency use in the facility is no longer needed. This will be ongoing weekly until such time. The SSD and Director of Nursing will continue to in-service staff 1 x every month for the next 6 months to ensure understanding, have time to ask questions and ensure any new staff have had the face to face in-service, even after the initial in-service with the hire packet. SSD will conduct 3 random resident interviews regarding safety and abuse 2 x a week for 6 months. This plan of correction will be monitored at the monthly Quality Assurance meeting until consistent substantial compliance has been met and/or agency use	

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	was removed on 7/31/23 when the facility in-serviced facility staff on abuse, neglect, and elopement identification, reporting, and behaviors, but the noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence. B.1. An incident report form, dated 7/22/23 at 5:01 A.M., indicated Resident G had reported to a CNA (Certified Nurse Aide) 8 that CNA 13 hit Resident E in the chest twice when care was provided. CNA 13 had been removed from the schedule until further notice. Social services staff interviewed other residents for abuse. A written letter was provided by CNA 13 that indicated Resident E did not wake up when CNA 13 called his name and told him what tasks were going to be performed. CNA 13 provided care and Resident E woke up agitated during care. During an interview on 7/24/23 at 9:15 A.M., Resident C indicated a staff member with the same name is mean and talked to him negatively. On 07/25/23 2:08 P.M., Resident C's clinical record was reviewed. The most recent quarterly MDS, dated 7/8/23, indicated Resident C was cognitively intact. On 7/25/23 at 1:32 P.M., Resident E's clinical record was reviewed. Diagnosis included, but were not limited to, dementia and anxiety. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 6/24/23 indicated Resident E's brief interview for mental status could not be assessed due to Resident E not being understood. Resident E was an extensive assist of 1 staff		is no longer needed in the facility. Corrective action completion date: 9/1//23	

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member for bed mobility, transfers, eating, and toileting.

A current behavioral symptoms care plan dated 7/23/23 indicated to stop care if Resident E tried to hit staff and have the nurse assist with care.

During the month of July, Resident E did not have any of the following behaviors documented: inappropriate behavior, mood changes, anxiety, anger, hitting, cursing, or screaming.

On 7/25/23 at 2:17 P.M., Resident G's clinical record was reviewed. The most recent quarterly MDS, dated 4/9/23, indicated Resident G was cognitively intact.

Resident G lacked a care plan related to fabricating stories.

During the month of July, Resident G did not have any of the following behaviors documented: anxiety, cursing, fabricating, or refusing care.

An untimed progress note dated 7/22/23 indicated "...this morn [morning] around 5:00 A.M. [staff name] came in here et [and] she must have thought I was asleep because [Resident E] was giving her a hard time et [and] I know he can be difficult @ [at] times but still what she did is not right. He was not wanting her to change him et [and] he kept resisting et [and] she punched him twice in the chest et [and] I seen et [and] heard it et [and] she hit him hard...I asked [Resident E] if he had been hit et [and] he looked @ [at] me et [and] said "yeah in my chest." This nurse then asked if I could see his chest et [and] he pulled his shirt up et [and] I assessed et [and] noted there to be an area pinkish in color to left side of his chest. Area is blanchable skin is intact. No other areas

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	noted during head-to-toe assessment. I did tell housekeeper earlier this morn [morning] after breakfast that [Resident E] wasn't acting like his normal self et [and] she said he does not seem to be staying completely bent over for some reason..." During an interview on 8/1/23 at 8:55 A.M., LPN (Licensed Practical Nurse) 29 indicated CNA 8 notified her that Resident G informed her that CNA 13 punched Resident E in the chest twice and she didn't realize that Resident G was awake. LPN 29 asked Resident E if he had been hit and Resident E stated, "yea, in my chest." LPN 29 assessed Resident E and noted he had a pink area on his chest. During an interview on 8/1/23 at 9:02 A.M., Resident G indicated CNA 13 came in the room to provide incontinence care to Resident E and did not pull the privacy curtain. Resident G witnessed CNA 13 hit Resident E in the chest twice. Since Resident G notified staff, Resident G indicated he was told CNA 13 was not allowed back in his room and his call light gets ignored. CNA 13 walked by the door and does not notify other staff since she had returned to work and he felt like they had retaliated on him. During an interview on 8/1/23 at 9:12 A.M., the Administrator indicated CNA 13 did not have any restrictions on which rooms she can provide care in. During an interview on 8/1/23 at 10:04 A.M., Staff 16 indicated CNA 13 was not allowed to provide care in Resident G's room per the DON (Director of Nursing). During an interview on 8/1/23 at 12:41 P.M., LPN			

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	29 indicated neither Resident E nor Resident G had behaviors. On 8/2/23 at 7:31 A.M., Resident E was observed in the common area slouched over in a wheelchair. A current abuse policy, dated 9/15/17, was provided 7/28/23 at 7:45 A.M. and indicated "It is the policy of [facility name] to ensure that each resident is free of physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect and involuntary seclusion. [name of facility] prohibits the mistreatment, neglect, abuse of residents and misappropriation of residents' property by anyone including staff, other residents, or persons from outside the facility..." This Federal tag relates to complaint IN00412693. 3.1-27(a)(1) 3.1-27(a)(3)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview and record review, the facility failed to assure the accuracy of the MDS (minimum data set) Assessment for 1 of 1 resident being investigated for restraints and 1 of 2 residents being investigated for side effects from psychotropic drugs. The MDS Assessment indicated they had restraints when they did not. (Resident 15, Resident 36) Findings include: 1. On 7/26/23 at 8:40 A.M., Resident 15 was	F 0641	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible	09/15/2023

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	155270	A. BUILDING 00 B. WING	08/02/2023

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	observed sitting in her wheelchair in the common area, awake, leaning to the left side with an arm cushion on the left side of the wheelchair. No trunk restraint was observed at that time. On 7/26/23 at 1:58 P.M., Resident 15 was observed sitting in her wheelchair in the common area eating fruit. She was pouring the juice from the fruit into a soft drink bottle. No trunk restraint was observed at that time. On 7/27/23 at 9:05 A.M., Resident 15 was observed sitting in her wheelchair in the common area eating breakfast. LPN 23 asked resident if she needed help with her breakfast and she indicated she was finished. No trunk restraint was observed at that time. On 7/27/23 at 3:35 P.M., Resident 15 was observed sitting in her wheelchair in the common area, awake, with arm cushion on the left side of the wheelchair. No trunk restraint was observed at that time. On 7/28/23 at 2:24 P.M., Resident 15 was observed sitting in her wheelchair in the common area going through her purse, left arm cushion in the wheelchair, head leaning to the left. No trunk restraint was observed at that time. On 7/27/23 at 10:45 A.M., Resident 15's clinical record was reviewed. Diagnosis included, but was not limited to, stroke, fibromyalgia, and chronic back pain. The most current quarterly MDS (minimum data set) Assessment, dated 4/29/23, indicated Resident 15 had moderate cognitive impairment, required extensive assistance of 1 for bed mobility and toilet use, limited assistance of 1 for transfers, total dependence of 1 for bathing, always incontinent of bladder and bowel, no falls,		allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Residents #15 and #36 MDS's were modified to reflect correct information. Neither resident has nor had, a restraint. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** An in-service education was conducted by the Director of Nursing Services with all licensed nurses including MDS Coordinator addressing the importance of identifying the use of restraints and documentation when needed. The 2 MDS' were modified to reflect correct information. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing Services, or designee, will conduct an audit of five (5) residents per week for 12 weeks then three (3) residents per week for 12 weeks. The residents, medical records and MDS will be reviewed to ensure no restraints are documented and/or put on the MDS inaccurately, unless it is accurate.	

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	and restraints used in chair or out of bed-trunk restraint used less than once daily. Review of the care plan dated 5/17/23, indicated adaptive devices used was a wheelchair with a cushion. Restraints were not marked. During an interview on 8/1/23 at 11:37 A.M., MDS Coordinator indicated Resident 15 did not have any restraints. She indicated that must have been marked in error. 2. On 7/25/23 at 3:06 P.M., Resident 36 was observed sitting up in her bed while staff was in the room. On 07/26/23 at 9:37 A.M., Resident 36 was observed sitting up in bed eating breakfast. She indicated she didn't get up in the chair very often because she had MS (multiple sclerosis) and was weak. No chair alarm was noted in the wheelchair at that time. On 7/26/23 at 12:55 P.M., Resident 36 was observed sitting up in wheelchair in the common area. No restraint or chair alarm were observed at that time. On 7/31/23 at 9:00 A.M., Resident 36 was observed propelling herself down the hall in her wheelchair. No restraint or chair alarm were observed at that time. On 7/25/23 at 2:29 P.M., Resident 36's clinical record was reviewed. Diagnosis included, but was not limited to, MS. The most current quarterly MDS Assessment, dated 6/10/23, indicated Resident 36 had severe cognitive impairment, needed limited assistance of 2 for bed mobility, transfer, and toilet use, restraint, other, used less		This plan of correction will be monitored at the monthly Quality Assurance meeting until such a time consistent substantial compliance has been met. Corrective action completion date: 9/15/23.	

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	than daily and chair alarm used less than daily. Care Plan, dated 6/21/23, indicated Resident 36 used a wheelchair and did not have a restraint. During an interview on 7/25/23 at 3:07 P.M., LPN 23 indicated Resident 36 did not have a chair alarm. During an interview on 8/01/23 at 11:37 A.M., MDS Coordinator indicated she thought that it was a mistake for restraints to be marked. During an interview on 8/02/23 at 10:52 A.M., MDS Coordinator indicated they do not have a written policy for MDS Assessments. She indicated they use RAI (Resident Assessment Instrument) manual to document information for MDS Assessments. 3.1-31(i)			
F 0655 SS=E Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders.			

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	(B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			
	Based on interview and record review, the facility failed to ensure a baseline care plan was initiated and completed for 4 of 7 newly admitted residents reviewed. A newly admitted resident lacked a baseline care plan and residents lacked interventions on baseline care plans. (Resident 33, Resident C, Resident G, Resident 29) Findings include: 1. On 7/25/23 at 2:17 P.M., Resident G's clinical	F 0655	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is	09/15/2023

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	record was reviewed. Resident G was admitted on 1/30/23. Diagnosis included, but were not limited to neuromuscular disorder and muscle wasting and atrophy. The most recent quarterly MDS (minimum data set) Assessment, dated 4/9/23 indicated Resident G was cognitively intact and required and extensive assist of 2 staff for bed mobility, transfer, and toileting. Resident 34's clinical record lacked a baseline care plan. 2. On 7/25/23 at 2:08 P.M., Resident 25's clinical record was reviewed. Resident 25 was admitted 11/2/22. Diagnosis included, but were not limited to, diabetes mellitus, schizophrenia, and blindness. The most recent quarterly MDS Assessment, dated 7/8/22, indicated no cognitive impairment. A baseline care plan, dated 11/2/22, indicated a safety concern of falls due to blindness, refusal of care and aggressive with staff, a regular thin liquid diet, shower preference of two times per week, and a goal of adjustment to new facility and environment. The baseline care plan lacked identification of a psychiatric diagnosis, and lacked interventions for the concerns listed. 3. On 7/25/23 at 1:53 P.M., Resident 33's clinical record was reviewed. Resident 33 was admitted 3/14/23. Diagnosis included, but were not limited to, dementia and anxiety. The most recent significant change MDS Assessment, dated 6/5/23, indicated a severe cognitive impairment, and two falls since the previous assessment. A baseline care plan, dated 3/14/23, indicated a safety concern of falls due to (blank), a pureed diet with thickened liquids, assistance with ADL (activities of daily living) (did not indicated level		submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Residents # 33 baseline care plan was updated to address a dx of dementia and anxiety with interventions. Resident # 25 baseline care plan updated to address psychiatric dx and interventions were added. Resident # 34 a baseline care plan was added to the record with interventions. Resident # 29 baseline care plan was updated to address dx of dementia, epilepsy, any psychiatric disorders, and interventions added. Resident #C baseline care plan was reviewed and updated as needed. Residents # 33, 25, 34, 29 and C were given a summary of their baseline care plan. A copy of the summary, signed by the resident, and/or resident's representative, and a facility representative was placed in the medical record. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all new admissions have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** All interdisciplinary care plan team	

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	of assistance), resident was confused, and a goal to improve current status to (blank). The baseline care plan did not address a diagnosis of dementia or anxiety, and lacked interventions for the concerns listed. 4. On 7/27/23 at 9:56 A.M., Resident 29's clinical record was reviewed. Resident 29 was admitted 9/19/23. Diagnosis included, but were not limited to, epilepsy, psychosis, anxiety, dementia, schizoaffective disorder, and mood disorder. The most recent quarterly MDS Assessment, dated 6/17/23, indicated a severe cognitive impairment. A baseline care plan, dated 9/19/22, indicated a goal of adjustment to facility, and a discharge goal to remain in the facility. The resident of the form was blank, did not address a diagnosis of dementia, epilepsy, dementia, any psychiatric disorders, and lacked interventions. On 8/2/23 at 9:45 A.M., the Director of Nursing (DON) indicated baseline care plans included immediate risks and should have some interventions listed. On 7/31/23 at 1:30 P.M., the Administrator provided a current non-dated Baseline Care Plan policy that indicated "The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to proved effective and person-centered care of the resident that meet professional standards of quality care ...The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. Initial goals based on admission orders. ii. Physician orders. iii. Dietary orders. iv. Therapy services. v. Social		members responsible for writing baseline care plans were re-educated on the facility's policy and procedure for developing *Baseline Care Plans,* which includes procedures for providing the resident and/or representative a written summary of their baseline care plan. The nursing staff was reeducated on implementation of the Baseline Care Plan and adding interventions as needed for the resident diagnoses. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing Services (DNS), or designee, will complete audits on all new admissions of baseline care plans for six (6) months. These audits will be completed to ensure that baseline care plan summaries are signed, complete, with interventions and being provided to residents, and that a copy has been placed in the medical record. Audit records will be reviewed by the Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 9/15/23	

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	services. vi. PASARR [Preadmission Screening and Resident Review] recommendation, if applicable ...b. Interventions shall be initiated that address the resident's current needs including: i. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk. ii. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living. iii. Any special needs such as for IV [intravenous] therapy, dialysis, or wound care. c. Once established, goals and interventions shall be documented ..." 3.1-30(a)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)			

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	(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to ensure care plan interventions and physician orders were followed for 2 of 5 residents reviewed for activities of daily living. A wanderguard was not monitored as ordered, and a blind resident was not informed where food was located on his plate as indicated in a care plan. (Resident 19, Resident 25) Findings include: 1. On 7/25/23 at 2:08 P.M., Resident 25's clinical record was reviewed. Diagnosis included, but were not limited to, blindness. The most recent	F 0656	Preparations or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth, on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance. 1. Immediate action(s) taken	09/15/2023

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	quarterly MDS (minimum data set) Assessment, dated 7/8/23, indicated no cognitive impairment, and a requirement of supervision with oversight, encouragement, or cueing with eating. A current nutrition care plan, initiated 11/2/22, indicated, but was not limited to, a non-dated intervention to explain to him where his food is on the plate due to blindness. On 7/24/23 at 12:15 P.M., Resident 25 was observed sitting in the dining room. Certified Nurse Aide (CNA) 8 was observed to set a plate of food in front of him. CNA 8 indicated to Resident 25 what was on the plate, but did not inform him where the the different food items were on the plate. On 7/31/23 at 12:26 P.M., Resident 25 was observed sitting in the dining room. Staff 5 was observed to set a plate of food in front of him. Staff 5 indicated to Resident 25 what was on the plate, but did not inform him where the different food items were on the plate. On 8/2/23 at 9:45 A.M., the Director of Nursing (DON) indicated staff should be serving Resident 25 meals by putting the tray in front of him, asking if he needed help, and letting him know what and where the food was on the plate. 2. On 7/25/23 at 1:50 P.M., Resident 19's clinical record was reviewed. Diagnoses included, but was not limited to, progressive neurological conditions and dementia. The most recent annual MDS, dated 4/29/23 indicated Resident 19's cognition could not be assessed. Current physician orders included, but were not limited to, "...CHECK FUNCTION OF WANDERGUARD TO L [left] ANKLE Q [every]		for the resident(s) found to have been affected include: Care plan(s) for residents #25 and #19 were reviewed and updated as indicated. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** All interdisciplinary care plan team members responsible for writing care plans were re-educated by the DON and Administrator on the facility's policy and procedure for developing Care Plans and revising as needed. All staff were in-serviced on informing Res#25 not just what was on the plate, but where on the plate. The in-service also included nurses to check function AND placement of the wander guards on each 12-hour shift. The facility does have policies regarding following physician orders and revising care plan interventions and they were used for this educational session. Nursing staff will be in-serviced on placement of wander guards and ensuring documentation matched where placement of guard is.	

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	SHIFT..." started 6/6/22. On 8/2/23 at 9:46 A.M., Resident 19 was observed in the common area on the opposite side of the facility of his room with a wanderguard placed on his right ankle underneath his pants. At that time, LPN (licensed practical nurse) 29 indicated the wanderguard should be checked daily and documented in the treatment book, and if the wanderguard is moved to the opposite leg of the resident a new order should be placed. A current wandering care plan, revised 7/22/23, indicated "Wandering, potential for elopement or safety risk related to Restless paces, Environmental stimuli- exit signs, people leaving, etc. to leave [unreadable]..." Current interventions included, but were not limited to, a wanderguard. The facility failed to check the function of the wanderguard on the following days/ shifts: May 7- night shift May 13- night shift May 26- night shift May 27- night shift June 7- day shift June 9- day and night shift June 16- night shift June 17- night shift June 18- day and night shift June 23- night shift June 24- night shift June 30- night shift July 3- day shift July 15- day shift July 16- day and night shift July 28- day shift July 29- day shift July 30- day and night shift July 31- day shift		Resident # 19 care plan was corrected as to which ankle the wander guard was placed. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator and IDT team members. All care plans will be updated as indicated, paying particular attention to wander guards and current interventions for any updates. The Director of Nursing Services, or designee, will complete up to 5 weekly audits of care plans, according to the MDS schedule of care plan meetings, for 12 weeks then 3 for random audits for 12 weeks. These audits will be completed to ensure that care plans are developed for residents and updated and/or revised as needed. Audit records will be reviewed by the Quality Assurance Committee for 6 months or until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 9/15/23	

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	On 7/31/23 at 1:30 P.M., the Administrator indicated there was not a specific policy that indicated staff were to follow physician orders and care plan interventions, but that it was the facility policy for staff to do so. 3.1-35(a) 3.1-35(g)(1)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORE OF DALE	510 W MEDCALF ROAD DALE, IN 47523

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	quarterly review assessments. Based on observation, interview and record review, the facility failed to ensure care plan conferences were completed and care plans revised for 1 of 1 resident being reviewed for falls and ADLs (activities of daily living) and 2 of 2 residents being reviewed for Unnecessary medication. Care plan conference was not completed for one resident, care plans were not revised for two residents receiving anticoagulants and one not updated to show outdated interventions. (Resident 9, Resident 11, Resident 5) Findings include: 1. On 7/29/23 at 10:10 A.M., Resident 9 was observed to have a bruise about 1 inch to 1 1/2 inches on top of left hand. At that time, she indicated she did not remember hitting it in any way. On 7/31/23 at 9:24 A.M., Resident 9 was observed to have a large circular bruise, lappeared to be 2 inches, on top of right wrist. On 7/25/23 at 3:12 P.M., Resident 9's clinical record was reviewed. She was admitted on 6/19/23. Diagnosis included, but were not limited to, major depressive disorder with psychotic symptoms, mild intellectual disabilities, Type 2 diabetes, and chronic embolism/thrombus deep vein BLE (bilateral lower extremities). The most current admission MDS (minimum data set) Assessment, dated 6/26/23, indicated Resident 9 was cognitively intact, needed extensive assistance of 1 for bed mobility and toilet use, extensive assistance of 2 for transfers, was frequently incontinent of bladder and occasionally incontinent of bowel and received an	F 0657	Preparations or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth, on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Care plan(s) for residents # 9,5 was reviewed and updated as indicated. Res # 9 now has an order to assess for bleeding and is care planned. Res# 5 had a care plan conference completed on 8/16/23 and care plans were updated. Res# 11 no longer resides at the facility. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** All interdisciplinary care plan team members responsible for writing care plans will be re-educated on	09/15/2023

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	anticoagulant for 7 days. Current physician orders included, but were not limited to, Eliquis 5 mg (milligrams) 1 tablet my mouth twice daily for hx (history) of DVT (deep vein thrombosis), dated 6/19/23. The physician orders lacked an order to assess for bleeding. The current care plan lacked a care plan to assess for bleeding. During an interview on 7/31/23 at 9:37 A.M., the DON indicated Resident 9 was swinging her arms around while staff was trying to change her brief yesterday morning. She indicated the resident could have hit her arm on the bed rail while she was swinging her arms around to cause the bruise on top of her wrist. 2. On 7/27/23 at 10:20 A.M., review of Resident 11's clinical record was reviewed. Diagnosis included, but were not limited to stroke and hyperlipidemia. The most current annual MDS Assessment, dated 7/1/23, indicated Resident 11 had a moderate cognitive impairment, needed extensive assistance of 1 for bed mobility, transfer and toilet use, always incontinent of bladder and bowel, and was on an anticoagulant for 6 days. Current physician orders included, but were not limited to, Eliquis 2.5 mg 1 tablet by mouth 2 times a day for stroke, dated 3/3/23. The physician orders lacked an order to assess for bleeding. The current care plan lacked a care plan to assess for bleeding.		the facility's policy and procedure for developing Care Plans and revising as needed as well as timely care plan meetings with the resident and/or representatives. The nursing staff will be reeducated on ensuring that orders for anticoagulants also have orders to assess for bleeding. MDS was educated on ensuring there are care plans for assessing for bleeding. Care plan(s) for residents # 9 and #5 were reviewed and updated as indicated. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** Care plans will be reviewed in accordance with the care plan review schedule by the MDS Coordinator and IDT members. All care plans will be updated as indicated. Care plan meetings will be scheduled weekly in accordance with the MDS schedule. Residents and/or representatives will be invited to attend the meetings. The schedule will be reviewed daily in the morning meetings and documented to ensure that the meetings are scheduled, residents and representative are invited, and the meeting is being held timely in	

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	During an interview on 8/1/23 at 9:51 A.M., the DON (director of nursing) indicated the chart should include both an order to assess for bleeding and a care plan to assess for bleeding for anyone on an anticoagulant. 3. On 7/24/23 at 12:53 P.M., Resident 5 was observed sitting in a wheelchair in his room. He was not wearing a helmet. On 7/26/23 at 8:35 A.M., Resident 5 was observed walking around in his room. He was not wearing a helmet. On 7/25/23 at 2:16 P.M., Resident 5's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's disease, anxiety, depression, bipolar, and schizophrenia. The most recent quarterly MDS (minimum data set) Assessment, dated 5/6/23, indicated Resident 5 had a mild cognitive impairment, required supervision with setup for all activities of daily living, was not on a toileting program, and was occasionally incontinent of bladder, and continent of bowel. A current risk for falls care plan, last revised 4/28/23, indicated, but was not limited to, an intervention to wear a helmet while out of bed, dated 10/17/22, and toileting program every two hours, dated 9/14/22. On 7/31/23 at 12:37 P.M., the Director of Nursing (DON) indicated falls were reviewed at every morning meeting, and care plan interventions were reviewed and updated at an Interdisciplinary Team (IDT) meeting following the morning meeting. She also indicated Resident 5 did not wear a helmet.		accordance with the MDS schedule. The Director of Nursing and/or designee, will complete 5 random weekly audits of care plans for 12 weeks then 3 for random audits for 12 weeks. Random audits will be completed to ensure that care plans are developed for residents and updated and/or revised as needed to ensure interventions are in place and the care plan meetings are completed per schedule. Audit records will be reviewed by the Quality Assurance Committee for 6 months or until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 9/15/23.	

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	On 7/31/23 at 10:51 A.M., Occupational Therapist (OT) 9 indicated they had attempted to have Resident 5 wear a helmet, but he refused. He indicated if Resident 5 did wear the helmet at all, it was for a very short amount of time. On 7/31/23 at 2:24 P.M., Certified Nurse Aide (CNA) 21 indicated Resident 5 was continent, and was not on a toileting program. Resident 5's most recent care plan conference was completed 3/29/23. The clinical record lacked a care plan conference, or an invitation to one since 3/29/23. On 7/27/23 at 8:20 A.M., the Social Services Director (SSD) indicated several care plan conferences had not been completed due to the facility not having a social worker for a period of time. She indicated they should have been completed every three months. A current, non-dated Care Planning - Resident Participation policy was provided on 7/31/23 at 1:30 P.M. and indicated "This facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care) ...2. The physician, other practitioner, or professional will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment and treatment alternatives/options...9. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences" 3.1-31(d)(3)			
F 0684 SS=D	483.25 Quality of Care			

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Bldg. 00	§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure medications were given as prescribed by the provider for 1 of 5 residents reviewed for Unnecessary Medications Review. The diuretic was not given twice a day as ordered and an antibiotic was given past the end date. (Resident 9) Findings include: On 7/26/23 at 9:34 A.M., Resident 9 was observed propelling herself in the wheelchair with her legs elevated. Both of her lower extremities were observed to be very swollen. On 7/25/23 at 3:12 P.M., Resident 9's clinical records were reviewed. Diagnosis included, but was not limited to, major depressive disorder with psychotic symptoms, mild intellectual disabilities, Type 2 diabetes, chronic embolism/thrombus deep vein BLE (bilateral lower extremities), and osteonecrosis of right femur. The most current admission MDS (minimum date set) Assessment, dated 6/26/23, indicated Resident 9 was cognitively intact, needed extensive assistance of 1 for bed mobility and toilet use, extensive assistance of 2 for transfers, incontinent of bladder occasionally and incontinent of bowel frequently. Medications in the 7 day look back period included the following:	F 0684	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 9 medication administration record, physician orders and physician order sheet were reviewed and updated as needed. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence**	09/01/2023

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	Antipsychotic 7 Antidepressant 7 Anticoagulant 7 Antibiotic 4 Diuretic 7 Opioid 7 Physician orders included, but were not limited to: Bumex 2 mg (milligrams) 1 po (by mouth) BID (two times a day) for edema, dated 6/19/23 Macrobid 100 mg 1 po BID for UTI (urinary tract infection), end date 6/19/23 Abilify 10 mg 1 tablet po daily for depression, dated 6/19/23 Sertraline 50 mg 1 tablet po at hs (bedtime) for depression, dated 6/19/23 Eliquis 5 mg 1 tablet po bid for hx (history of deep vein thrombosis), dated 6/19/23 Oxycodone HCL (hydrochloride) 15 mg 1 tablet po bid for pain, dated 6/19/23 Review of the MAR (medication administration record) from 6/19/23 through 6/30/23 indicated Bumex 2 mg was given one time a day instead of two times a day and Macrobid was given from 6/19/23 through 6/22/23 when the end date was 6/19/23. Nurse's Notes indicated the following: 6/19/23 12:30 P.M. "Up in w/c [wheelchair], alert x 3. No c/o [complaint of] voiced. Swelling noted bilateral lower extremities and feet. Ate well, fed herself at lunch." LPN 23 6/20/23 8:30 A.M. " B/P [blood pressure]-150/88 T [temperature]-98 P [pulse]-60 R [respirations]-20 O2 sat [oxygen saturation]-95% on RA [room air]. No c/o pain @ [at] present time. Speech is clear. Stands et [and] pivots to go to bathroom. Bilateral lower ext [extremities] swollen & [and] red.		**include:** An in-service will be conducted by the Director of Nursing with all licensed nursing staff addressing physician orders, writing it on the physician order sheet and the MAR and to recheck it to ensure that it was transcribed properly on all documents. The MAR will be marked when the end date is for medication prescribed. A copy of the new orders will be given to the DON and/or designee who will review the record and MAR to ensure the orders match. The end of the month rewrite process will be second check to ensure the MAR and physician order sheet all match. **Of note--***The facility has taken measures to help eliminate errors going forward, by implementing an electronic charting system within the facility. The electronic charting system will help eliminate errors transcribing from place to place via handwriting. The electronic charting system will take approximately 3 to 4 months to be fully implemented but the facility began the installation process a few weeks ago.* 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Director of Nursing Services,	

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	Refuses to elevate." documented by LPN 23. Nurse's Notes lacked notification of provider that Bumex 2 mg was only given daily instead of twice a day from 6/19/23 through 6/30/23. Skin assessment dated 6/16/23 for Resident 9 indicated 3-4 + (plus) edema to bilateral lower extremities. The medical record lacked additional skin assessments for edema. Monthly Pharmacy Review was completed on 7/3/23. No administration errors were documented regarding Bumex. The medical record lacked Pharmacy Review for the continued edema in bilateral lower extremities. During an interview on 7/29/23 from 10:10 - 10:32 A.M., Resident 9 indicated she didn't like people looking at her legs because they were swollen and painful. During an interview on 7/31/23 at 10:58 A.M. DON (Director of Nursing) indicated it depends on who does the admission and takes the orders on who writes out the order sheet and the MAR sheet. She indicated for the Bumex 2 mg 1 po bid, the MAR did only show it was given once a day and should have been two times a day. For the Macrobid 100 mg 1 po bid UTI Ends 6/19/23, she indicated she would have to look at the admission orders and when Resident 9 arrived to see why it was given the extra days, maybe we didn't have it when she was admitted. A Resident Assessment Policy was requested and not provided. A Medication Orders Policy was provided on 8/1/23 at 9:45 A.M. that indicated "...4.		or designee, will conduct an audit of 5 residents weekly for twelve (12) consecutive weeks, including any new admission, then 3 residents weekly for twelve (12) weeks, including any new admissions. These audits will ensure that the order was written according to the physician order and transcribed accurately on the MAR and physician order sheet. The Director of Nursing and designee will complete the monthly rewrites and follow up on new orders/progress notes matching the MAR/TAR. Any discrepancies will be clarified with the physician/NP. Any noncompliance found during the audits will result in reeducation and counseling's of non-compliant staff, up to and including termination. Audit records will be reviewed by the Quality Assurance Committee monthly for 6 months or until such a time consistent substantial compliance has been achieved as determined by the committee. 9/1/23	

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	Documentation of Medication Orders: a. Each medication order should be documented with the date, time and signature of the person receiving the order. The order should be recorded on the physician order sheet, and the Medication Administration Record (MAR). b. Clarify the order..." 3.1-37(a)			
F 0688 SS=E 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 observation, interview, and record review, the facility failed to ensure a restorative program was initiated and implemented for residents with conditions that would benefit from such a program. A restorative nursing program was not in effect for 1 of 1 paralyzed residents observed, and 5 of 5 residents observed with contractures. (Resident 1, Resident 11, Resident	F 0688	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who	09/15/2023

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	15, Resident 6, Resident 14, Resident 24) Findings include: 1. On 7/24/23 at 12:19 P.M., Resident 1 indicated she has had a decline in her lower extremity function since she had been in the facility. She indicated she was unable to move her legs, and was supposed to have range of motion (ROM) exercises in her lower extremities daily but staff did not provide it. On 7/31/23 at 12:21 P.M., Licensed Practical Nurse (LPN) 23 indicated Resident 1 should have been offered ROM exercises daily as she was a quadriplegic and needed it done. 2. On 7/26/23 from 8:29 A.M. through 8:40 P.M., the following residents were observed on the East Hall: Resident 11 was observed sitting in a wheelchair in her room with her right arm contracted. Resident 15 was observed sitting in a wheelchair leaning to the left side with a cushion between the resident and the left arm of the wheelchair. 3. On 7/28/23 from 3:22 P.M. through 3:24 P.M., the following residents were observed on the East Hall: Resident 14 was observed in the common area with her right hand contracted. Resident 24 was observed lying in bed with her right hand contracted. Resident 11 was observed sitting in a wheelchair in her room with her right hand contracted. Resident 6 was observed self propelling in the hall in a wheelchair with a splint in his right contracted hand. On 7/28/23 at 2:50 P.M., the MDS Coordinator		draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 1 no longer resides in the facility. Resident # 11 no longer resides in the facility. Resident # 15 was screened for therapy and/or a restorative program. Resident # 6 was screened for therapy and/or a restorative program. Resident # 14 was screened for therapy and/or a restorative program. Resident # 24 was screened for therapy and/or a restorative program. 2. Identification of other residents having the potential to be affected was accomplished by: All residents of the facility who require splints and/or ROM to prevent decline, according to person-centered care plans, have the potential to be affected by this practice. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** A log of residents requiring use of splints and/or ROM, in accordance with care plan review, was created by the MDS Nurse	

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	indicated there were no residents currently in the facility on a restorative program. At that time, the Director of Nursing (DON) indicated there was no restorative nursing program because there was not enough staff to support it. On 7/31/23 at 1:30 P.M., a current non-dated Restorative Nursing Documentation policy was provided and indicated "The facility maintains complete, accurate, and organized documentation of restorative treatments and the response to those treatments" 3.1-42(a)		and the Therapy Director and will be updated monthly. MDS Nurse and/or Therapy Director will observe splints and/or ROM monthly and refer residents to therapy department if any problems are noted. Res # 15, 6, 14, 24 were screened for therapy and/or a restorative program. The MDS Nurse and Director of Therapy Services provided inservice education for direct care staff regarding the use of splints and ROM for residents requiring same. ROM/Splints were added to the Care sheets utilized by the aides to ensure all aides know who is on the programs. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** Therapy Director and MDS nurse will observe resident care 5 x week for 4 weeks for those residents requiring the use of splints and/or ROM to ensure proper and consistent use of the splints and the ROM. After the 4 weeks, the MDS Nurse and Therapy Director will observe care for 3 residents requiring splints and/or ROM three (3) times per week for 8 weeks then 1 x a week for 8 weeks to assure the proper and consistent use of recommended splints and/or ROM. Results will be reviewed by the	

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			Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 9/15/23	
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision and assistance devices to prevent accidents for 4 of 6 residents reviewed for accidents. A resident at risk for falls lacked a falls care plan at the time a fall occurred with an injury, a resident with multiple falls lacked updated interventions following falls, a quadriplegic resident using side rails had legs stuck in the side rails, and residents with a wanderguard were observed turning the alarm off when activated. (Resident 33, Resident 5, Resident 1, Resident 29) Findings include: 1. On 7/27/23 at 8:24 A.M., Resident 33 was observed lying in bed with a sheet over his whole body, head to toe. A fall mat was observed on the	F 0689	Preparations or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth, on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 33 falls care plans/interventions have been	09/15/2023

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	155270	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORE OF DALE	510 W MEDCALF ROAD DALE, IN 47523

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	floor to the side of the bed. On 7/25/23 at 1:53 P.M., Resident 33's clinical record was reviewed. Resident 33 was admitted 3/14/23. Diagnosis included, but were not limited to, dementia and anxiety. The most recent significant change MDS (minimum data set) Assessment, dated 6/5/23, indicated a severe cognitive impairment. Resident 33 required supervision with setup assistance with bed mobility and eating, and limited assistance of one staff with transfers and toileting. Resident 33 had experienced a fall in the month prior to admission with no fracture, no falls prior to then, and had two falls since admission or previous assessment, one with no injury, and one with a major injury. A current non-dated falls care plan indicated the following interventions: use fall risk assessment to identify risk factors, report falls to physician and responsible party, monitor for side effects of medications, therapy per order, and provide wheelchair. No interventions were dated. A current falls care plan, dated 5/25/23, indicated, but were not limited to, the following intervention: mat to floor on the left side of the bed, dated 5/8/23. A current hospice care plan, dated 5/24/23, indicated Resident 33 was placed on hospice due to a nontraumatic acute subdural hematoma. A baseline care plan, dated 3/14/23, indicated falls as a concern, but no interventions were documented on the form. A fall risk assessment form, dated 3/14/23, indicated resident was a high risk for falls.		updated and all interventions in place. Resident #5 falls care plans/interventions have been updated and all interventions in place. Resident # 1 no longer resides in the facility. Resident # 29, #5, #240 can no longer turn off wander guard alarm. The wander guard alarm push button (to turn off the sounding alarm) was replaced with a keypad with a code that only staff know to deactivate the sounding alarm after checking the area. 2. Identification of other residents having the potential to be affected was accomplished by: All residents have the potential to be affected by the deficient practices. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** All nursing staff were in-serviced on the facility policy for *Accidents and Supervision* and how and where to document behaviors/incidents/falls/side rails/interventions and supervision checks. All staff were in-serviced on the wander guard system, checking the area before deactivation of the alarm and find who set it off. A reminder sign was placed by the keypads for staff to search the area before deactivating the alarm. All resident	

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	A resident fall, incident, injury of unknown etiology form, dated 5/5/23, indicated Resident 33 fell on 5/5/23 when attempting to stand up unassisted. The resident fell face first onto the floor in the West Hall common area. Resident 33 had a laceration on the right brow bone, and was sent to the Emergency Room (ER) for evaluation and treatment. Hospital records indicated no fracture. Nurse's notes included, but were not limited to, the following: 5/5/23 at 8:40 P.M. A Registered Nurse (RN) from the hospital called to notify the facility that Resident 33 was being transferred to a trauma ER due to testing showed a subdural hematoma. 5/8/23 at 5:50 P.M. Indicated Resident 33 had sutures on his right brow bone. 5/23/23 at 10:40 A.M. The Nurse Practitioner (NP) recommended hospice and comfort foods. On 8/2/23 at 9:47 A.M., the Director of Nursing (DON) indicated the intervention listed on Resident 33's fall care plan on 5/9/23 for a fall mat beside the bed was probably put in related to the 5/5/23 fall. She indicated the intervention was not appropriate related to the fall occurring in the common area. She indicated she did not know why a falls care plan was not implemented prior to the fall. 2. On 7/24/23 at 12:53 P.M., Resident 5 was observed sitting in a wheelchair in his room. He was not wearing a helmet. Non-skid strips were observed in front of the toilet in the bathroom. His bed was observed against the wall.		incidents/accidents/supervision reports will be reviewed 5x week ongoing, by the IDT management team to ensure appropriate implementation of safety interventions including updating the plan of care has been completed. The Director of Nursing and/or designee will bring all new incident reports to IDT meetings for this review. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The IDT management team will review new incident reports 5 x week, ongoing, to ensure appropriate interventions are implemented and the updated plan of care is complete. The Director of Nursing, or designee, will complete 5 weekly chart audits for 12 weeks and then 3 weekly chart audits for 12 weeks to review all incident reports and side rail assessments to ensure that appropriate documentation and interventions have been put in place to reduce the risk of resident accidents/incidents from fall and/or side rails, the effectiveness, and that care plans have been updated to reflect these interventions. Audited records will be reviewed by the Quality Assurance Committee for 6 months or until such time consistent substantial	

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	On 7/26/23 at 8:35 A.M., Resident 5 was observed walking in his room. He was not wearing a helmet. On 7/25/23 at 2:16 P.M., Resident 5's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's disease, anxiety, depression, bipolar, and schizophrenia. The most recent quarterly MDS Assessment, dated 5/6/23, indicated Resident 5 had a mild cognitive impairment, required supervision with setup for all activities of daily living, was not on a toileting program, and was occasionally incontinent of bladder, and continent of bowel. Resident 5 had experienced one fall since admission or previous assessment with no injury. A current falls care plan, dated 7/17/20 and last revised 4/29/23, included, but was not limited to, the following interventions: strips to bathroom floor dated 6/25/22, area free of clutter dated 8/4/22, bed against the wall dated 8/11/22, toileting program every two hours dated 9/14/22, and helmet to head while out of bed dated 10/17/22. Another falls care plan, dated 5/25/23, included, but was not limited to, the following interventions: bed against the wall and strips to the bathroom floor, neither intervention was dated. Falls risk assessments were completed on the following dates from 6/9/22 through 5/20/23: 6/9/22 6/unreadable day/22 8/14/22 8/22/22 9/10/22 9/14/22 2/15/23 3/2/23 2/15/23 (again)		compliance has been achieved as determined by the committee. Corrective action completion date: 9/15/23	

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	4/4/23 5/20/23 All falls risk assessments indicated a high risk for falls. An individual support plan note, dated 5/25/23, indicated Resident 5 had poor decisions related to falls. Resident was non-compliant and did not use wheelchair or walker correctly. Would try to do things on his own that were unsafe that caused falls. Resident 5 would run, stand on his wheelchair, and push the wheelchair. From 8/2022 through 7/2023, Resident 5 experienced the following 15 falls: Fall 1 8/4/22 at 1:45 P.M. Unwitnessed fall. Resident was up with a rolling walker, went into the business office, lost balance and fell hitting head on the wall. A nurse's note, dated 8/4/23 indicated "... will continue [with] current plan of care". Neuro checks were requested and not provided. The falls care plan was updated with keep personal items in reach, staff educated, and neuro checks as needed. Fall 2 8/11/22 at 3:30 A.M. Unwitnessed fall. Resident was walking down the East Hall with blood dripping fro the left eye. Staff assisted to his room where he indicated he had fallen out of bed and hit the windowsill. Checks were completed every 15 minutes from 3:30 A.M. through 7:00 A.M. Neuro checks were started on 8/11/23 at 3:30 A.M., and completed at 3:45 A.M., 4:00 A.M., 4:15 A.M., 5:15 A.M., and 5:45 A.M. No further neuro checks were documented. The falls care plan was updated with an intervention to put the bed against the wall.			

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	Fall 3 9/10/22 at 2:00 P.M. Unwitnessed fall. Resident lost balance and fell to the ground. The intervention listed on the form was for staff to remove any clutter throughout shift (already on the care plan, dated 8/4/22). Neuro checks were requested and not provided. The falls care plan was not updated. Fall 4 9/13/22 at 1:20 P.M. Unwitnessed fall. Resident indicated he was going to the bathroom, became weak, and fell. He indicated his right hip hurt, and had a 3 cm (centimeter) red area on the left forehead, but indicated he did not hit his head. Resident was sent to the ER for an x-ray which showed no fracture. Neuro checks were requested and not provided. The falls care plan was updated the following day the an intervention for a toileting program every 2 hours. Fall 5 9/14/22 at 12:25 P.M. Witnessed fall. Resident was returning to the hall after an activity and fell. He did not hit his head. Resident was educated to use the wheelchair. The falls care plan was not updated with a new intervention. Fall 6 9/20/22 at 10:50 A.M. Witnessed fall. Resident was running down the hall with a walker and slipped on the floor. Did not hit his head. The walker was taken from the resident, and he was educated to use the wheelchair when his gait was unsteady. The falls care plan was not updated with a new intervention. Fall 7 10/17/22 (no time documented) in the evening. Witnessed fall. Resident lost his balance and fell			

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	in the hallway, hitting the right side of his head. Resident had a small 0.5 cm area on the right side of head. Neuro checks were requested and not provided. The falls care plan was updated with the intervention for resident to wear a helmet when out of bed. Fall 8 11/17/22 at 9:15 A.M. Witnessed fall. Resident was upset after a CNA removed his curtains out of his room. The resident pulled the curtains out of the CNA's arms, ran and fell on the floor bumping his forehead. Staff member was educated. Neuro checks were requested and not provided. The falls care plan was not updated with a new intervention. Fall 9 2/15/23 at 9:00 A.M. Witnessed fall. Resident was standing in the West Hall lobby, and was unsteady. Staff lowered resident to the floor. Resident was reminded to slow down. The falls care plan was not updated with a new intervention. Fall 10 2/15/23 at 12:30 P.M. Unwitnessed fall. Resident was speed walking in the hall and tripped over his feet. As the resident was falling, he held onto the walker and did a 1/2 roll, then got tangled up in the walker. The falls care plan was not updated with a new intervention. Fall 11 2/15/23 at 4:00 P.M. Witnessed fall. Resident was speed walking in the hall, tripped, and again got tangled up in the walker. The falls care plan was not updated with a new intervention. Fall 12			

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	2/21/23 at 9:45 A.M. Witnessed fall. Resident was walking very fast, tripped and fell to the floor. He jumped right back up. The falls care plan was not updated with a new intervention. Fall 13 4/4/23 at 1:55 P.M. Witnessed fall. Resident was putting his clothes in the closet and fell into the closet door. He indicated he bumped his head. Neuro checks were completed. The falls care plan was not updated with a new intervention. Fall 14 5/16/23 at 1:00 P.M. Witnessed fall. Resident was running in the dining room and fell into the basketball goal. Resident was educated to not run and to use a walker. The falls care plan was not updated with a new intervention. Fall 15 5/19/23 at 8:30 P.M. Witnessed fall. Resident was in the doorway trying to sit on his rolling walker. The brakes were not engaged and it spun around. Resident fell to the floor landing on his buttocks. Resident was reminded to put the brakes on the walker if he plans to use it as a seat. The falls care plan was not updated with a new intervention. On 7/31/23 at 9:06 A.M., Licensed Practical Nurse (LPN) 23 indicated Resident 5 had a history of falls due to running. She indicated staff should have made sure resident had appropriate footwear, and he was using his walker. Staff should educate him not to run and to ask for help. On 7/31/23 at 12:37 P.M., the Director of Nursing (DON) indicated falls were reviewed at every morning meeting, and care plan interventions were reviewed and updated at an Interdisciplinary Team (IDT) meeting following the morning			

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meeting. She indicated she would expect neuro checks to be completed after an unwitnessed fall, or if the resident hit their head.

On 7/31/23 at 10:51 A.M., Occupational Therapist (OT) 9 indicated they had attempted to have Resident 5 wear a helmet, but he refused. He indicated if Resident 5 did wear the helmet at all, it was for a very short amount of time.

On 7/31/23 at 2:24 P.M., Certified Nurse Aide (CNA) 21 indicated Resident 5 was not on a toileting program because he was continent and did not need to be on one.

3. On 7/24/23 at 12:26 P.M., Resident 1 was observed lying in bed with 1/2 bilateral (both sides) side rails up at the head of the bed, and 1/4 bilateral side rails up at the foot of the bed. At that time, her right food was observed falling out of a boot heel protector, and was in the slats of the bottom side rails. Resident 1 indicated that had happened in the past as well, and when it did, she did feel pain from it.

On 7/25/23 at 1:44 P.M., Resident 1's clinical record was reviewed. Diagnosis included, but were not limited to, quadriplegia, anxiety, depression, and schizophrenia. The most recent quarterly MDS Assessment, dated 7/1/23, indicated Resident 1 was cognitively intact, and required extensive assistance of two staff with bed mobility.

Current physician orders included, but were not limited to:
Bilateral 1/2 side rails as enablers, dated 11/17/21.

A current ADL self-care deficit care plan, revised 7/1/23, indicated but was not limited to, an

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	intervention for 1/2 side rails as enablers x 2. On 7/28/23 at 11:37 A.M., LPN 23 indicated Resident 1 had an order for 1/2 bilateral side rails, and currently had 1/2 bilateral side rails at the head of the bed, and 1/4 bilateral side rails at the foot of the bed. At that time, Resident 1 indicated she used all of the side rails as enablers. A bed rail consent, dated 5/26/22, signed by the resident and DON indicated "I do voluntarily consent to the use of bed rails as recommended ..." 1/2 side rails bilaterally as the resident requested to be used at all times while the resident was in bed. On 7/28/23 at 1:23 P.M., the DON indicated Resident 1 was care planned and consented for 1/2 side rails which she currently had at the head of her bed. She indicated Resident 1 had been requesting lately for all 4 side rails to be put up to feel more secure, but did not have an order for all 4 side rails to be up. At that time she indicated a physician order, assessment, and care plan would be needed for the use of the additional side rails. On 7/29/23 at 10:40 A.M., Resident 1 was observed lying in bed with 1/2 side rails up bilaterally at the head of the bed, and 1/4 side rails bilaterally at the foot of the bed. On 7/31/23 at 9:09 A.M., CNA 21 indicated Resident 1 should have had her feet in the boots, and as long as they were, they would not get stuck in the rails. He indicated if Resident 1's feet were coming out of the boots, staff should prop a pillow between her feet and the rail. 4. The following staff and residents were observed to disarm the alarms:			

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On 7/27/23 at 9:56 A.M., Resident 29's clinical record was reviewed. Resident 29 was admitted 9/19/23. Diagnosis included, but were not limited to, dementia, anxiety, depression, and schizophrenia. The most recent quarterly MDS Assessment, dated 6/17/23, indicated a severe cognitive impairment.

An elopement risk assessment, dated 5/1/23, indicated Resident 29 had a high risk of elopement.

Current physician orders included, but were not limited to:
Wanderguard to right ankle, dated 9/19/22.

A current mood and behavior care plan, revised 6/23/23, indicated Resident 29 had a wanderguard.

On 7/28/23 at 10:00 A.M., Resident 29 was observed walking past the doors by the shower room when a very loud alarm was activated. Resident 29 turned around and pressed a button by the doors that turned the alarm off.

On 7/28/23 at 1:33 P.M., the Assistant Director of Nursing (ADON) indicated the very loud alarm that sounded was activated by the wanderguard system. She indicated the activation area was at the doors by the shower room and had a radius of six feet. She indicated the alarm would sound constantly due to residents walking to the dining room or activity room, and when residents with a wanderguard were in the shower room. She indicated the alarm was placed there because just beyond that area was a short hall to the right that the residents would try and exit from.

5. On 7/31/23 at 2:25 P.M., Resident 240 was

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	observed walking down the hall toward the dining room with a wanderguard around her right ankle. A very loud alarm was activated when she got close to the doors by the shower room and she kept walking. At the same time, the Maintenance Supervisor was observed walking the other way from the dining room. The Maintenance Supervisor pushed a button on the wall as he was walking past the doors by the shower room that turned off the alarm, then kept walking. Resident 240 had not yet past the short hall on the right when the alarm was turned off. 6. On 8/1/23 at 10:21 A.M., Resident 5 was observed walking past the doors by the shower room with a rolling walker when an alarm was activated. Resident 5 pushed the button to turn the alarm off and it came on again. Resident 5 turned around, pushed the button again, and the alarm turned off. At that time, there were no staff observed in that hall. On 8/2/23 at 8:51 A.M., the DON indicated yes, the residents turned the wanderguard alarms off. She indicated the alarms went off several times a day and staff had become immune to them sounding, and tune them out. She indicated they went off so much that staff would just turn them off without thinking. She indicated several residents with mental health disorders could be triggered by how loud the wanderguard alarm was, but was currently unsure how to fix the problem. On 7/31/23 at 1:30 P.M., a current non-dated Accidents and Supervision policy was provided and indicated "The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This			

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	includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring for effectiveness and modifying interventions when necessary" On 7/31/23 at 1:30 P.M., a current non-dated Fire Alarm and Door System policy was provided and indicated "Only trained staff can silence or reset fire alarm". At that time, the DON indicated the policy also included the wanderguard alarm system, and that only staff should turn off the alarm. 3.1-45(a)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is			

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	155270	A. BUILDING 00 B. WING	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORE OF DALE	510 W MEDCALF ROAD DALE, IN 47523

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	not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on observation, interview, and record review, the facility failed to ensure competent staffing as determined by the state professional licensing agency during 4 of 35 days reviewed for staffing. A nurse with a probationary license was not supervised while working. (West Hall, Resident B) Finding includes: On 7/26/23 at 1:00 P.M., LPN 29 was observed working as the nurse on the West hall. During a review of employee licenses on 7/28/23 at 2:30 P.M., LPN 29's license status was listed as "probation." The status of the license had went from "suspended" to "probation" on 8/15/2018. Correspondence with the state professional licensing agency on 7/31/23 at 10:14 A.M., included that an LPN with a license on probation may not work in an unsupervised setting. During a review of daily staff posting sheets from 6/25/23 to 7/31/23 on 7/31/23 at 11:00 A.M., LPN 29 had worked on the West Hall, unsupervised by a Registered Nurse (RN), on 7/22/3, 7/9/23, 7/4/23, and 6/25/23.	F 0726	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Res # B no longer resides at the facility. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** The Director of Nursing will	09/20/2023

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	On 7/4/23, LPN 29 was providing care for Resident B on the West Hall. Resident B was on 15 minute checks due to suicidal ideation at the time, and was court ordered to remain in the facility. LPN 29 allowed Resident B to leave the facility to attend a 4th of July celebration. Resident B did not return to the facility following that leave of absence. During an interview on 7/31/23 9:51 A.M., the facility administrator indicated they were unaware that LPN 29's license was on probation. During an interview on 7/31/23 at 11:30 A.M., the DON (Director of Nursing) confirmed that no RN's were in the building on 6/25/23, 7/4/23, 7/9/23, and 7/22/23. The DON indicated there was no excuse for not ensuring that LPN 29's license was active and in good standing at the time of hire in January of 2023. On 7/31/23 at 1:30 P.M., the facility administrator supplied a facility policy titled Nursing Services and Sufficient Staff, dated 10/2022. The policy included, "It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. ...4. The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for resident's needs as identified through resident assessments..." 3.1-14(s)		ensure, while preparing the schedule, that LPN 29 will only be scheduled on days that an RN is on duty. Variations of her schedule will be made to accommodate that an RN is present. LPN 29 has brought in the form required to submit quarterly while her license is on probationary status. The Director of Nursing will be submitting the form every quarter. LPN 29 was educated on the importance of ensuring her employer knew about her license and submitting a form and they were submitting the forms quarterly and if she didn't know, to ask if they had completed yet. All licensed staff hired by the facility will have licenses checked prior to job offer. Any probationary licenses will be investigated, and the Administrator will be notified immediately before a job offer is extended. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing and/or designee audited all licensed staff to ensure no other probationary or suspended licenses are present. The Director of Nursing and/or designee will check licenses prior to hiring any nurses or aides.	

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			All licenses will be audited monthly to ensure that renewals are completed and there are no expired licenses for aides or nurses. Any noncompliance will result in counseling, up to and including termination. Audited records will be reviewed monthly by the Quality Assurance Committee until such a time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 9/20/23	
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to ensure at least 8 consecutive hours of Registered Nurse (RN) coverage based on	F 0727	Preparation and/or execution of this plan do not constitute admission or agreement by the	09/20/2023

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	submitted payroll-based journal (PBJ) information and during 4 days in a review period from 6/2023 to 7/2023. RN coverage was lacking on weekends and a holiday. Finding includes: During a review of the facility's PBJ information on 7/24/23 at 9:10 A.M., the facility lacked RN coverage on 1/28/23, 1/29/23, 2/12/23, and 3/25/23. During a review of daily staffing sheets from 6/2023 to 7/2023, the facility lacked RN coverage on 6/25/23, 7/4/23, 7/9/23, and 7/22/23. During an interview on 7/27/23 at 1:00 P.M., the facility administrator confirmed that the PBJ information was accurate and that the facility did not have RN coverage during weekend submitted and that it has been an ongoing issue especially on weekends. During an interview on 7/31/23 at 11:30 A.M., the DON (Director of Nursing) confirmed that no RN's were in the building on 6/25/23, 7/4/23, 7/9/23, and 7/22/23. On 7/31/23 at 1:30 P.M., the facility administrator supplied a facility policy titled Nursing Services and Sufficient Staff, dated 10/2022. The policy included, "It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. ...8. Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week." 3.1-17(b)(3)		provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: A new ad was placed online for hiring of RN staff members. Wages have been increased to attract more RNs to apply. Signage has been placed in the yard by the roadside for staffing needs. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** Anyone involved in nurse scheduling, ie: DON, ADON, Scheduler etc., will be in-serviced by the Administrator regarding the facility policy to ensure there is RN coverage 8 hours a day, 7 days a week, scheduled. Should RN staff not be available, the facility will make every effort to	

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			schedule an RN through Agency Staffing. The Director of Nursing is RN coverage at least 5 days a week. An ad to hire has been running on INDEED for RNs with increased wages. To date, one RN has been hired as PRN and we will continue to seek RN staff through online ads and agency staff as needed. The Director of Nursing will approach schools offering the nursing programs to inform them of our need to hire RN's and availability of job opportunities. Signage was placed in the front yard at the roadside regarding hiring Nurses and Aides. The Administrator is exploring social media to set up an account for potential staff to see ads that we are hiring. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON/Administrator will review the nursing schedule weekly, ongoing, to ensure an RN is scheduled 8 hrs. a day/7 day a week. Should an RN not be scheduled, every attempt will be made to ensure that an RN will be scheduled through Agency Staffing. Schedules will be reviewed by the Quality Assurance Committee	

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			until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 9/20/23	
F 0745 SS=D 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 observation, interview, and record review, the facility failed to ensure appropriate and timely social services were provided to meet the resident's needs for 1 of 1 resident reviewed for resident to resident conflict. (Resident 9) Findings include: On 7/26/23 at 9:34 A.M., Resident 9 was observed in a wheelchair propelling herself in the hallway. At that time, she indicated her roommate yelled at her last night and that morning and she had talked to Social Services about it. On 7/27/23 at 1:39 P.M., Resident 9 was observed in her wheelchair propelling herself in the hallway. At that time, she indicated her roommate was moving out of the room tomorrow. On 7/25/23 at 3:12 P.M., Resident 9's clinical record was reviewed. She was admitted on 6/19/23. Diagnosis included, but were not limited to, major depressive disorder with psychotic	F 0745	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: A program to assist resident # 9 to resolve her conflict with peers and her staff has been developed. Resident #9 was referred to counseling per her request with the facility psych provider and a	09/13/2023

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	symptoms, and mild intellectual disabilities. The most current admission MDS (minimum data set) Assessment, dated 6/26/23, indicated Resident 9 was cognitively intact, needed extensive assistance of 1 for bed mobility and toilet use, extensive assistance of 2 for transfers, was frequently incontinent of bladder and occasionally incontinent of bowel. Progress notes included, but were not limited to the following: A nurse's note, dated 7/6/23 at 10:00 A.M., indicated roommate was calling Resident 9 names. SSD (Social Services Director) was notified and spoke to this resident. A progress note by NP (Nurse Practitioner), dated 7/18/23, indicated "Still adjusting to facility. She is having issues with one of her roommates currently though. SS (Social Services) aware, along with nursing and they are trying to get her moved as soon as possible... Somewhat upset regarding roommate situation but otherwise no changes noted today." A progress note from Social Services, dated 7/26/23, indicated "SS met with resident again r/t [related to] her conflict with roommate. SS met with resident yesterday and questioned any concerns-only temp [temperature]. To Assist-speak all residents. Today Resident reported issue last night. SS reported to administrator. Interviewed staff and both residents. Resident reported roommate yelling and calling her names. Should [sic] alternative room . Attempting to assess compatibility to what rooms for resident or other peer involved." The previous progress notes from Social Services were dated 6/19/23 and 6/26/23. The chart lacked		referral to BDDS to review other options for resources that are available. Resident #9 was scheduled to see provider on 8/17/23 and BDDS on 8/18/23. Social Service meets with resident #9 1 time per week routinely and as needed. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents with intellectual disabilities have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** All Staff will be in-service on an Introduction to Intellectual Disabilities on 8/25/23. SSD will be in-serviced by SSD consultant on requirements of providing and documenting on medically related social service concerns and interventions as well as the importance of continually educating the staff on developmental disabilities, Psychosocial Disorders, Substance Abuse, and Trauma. Social Services will continue to monitor residents' interactions with peers and/or roommates. Social Services will continue to monitor, and document reported	

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	Social Services notes from 7/6/23 or 7/25/23 to show Social Services talked to Resident 9 about her conflict with the roommate or coming up with a solution. On 7/26/23 an Incident Report was filed with the State about the conflict between roommates after Social Services was interviewed. The roommate was moved to a different room 2 days later. A nurse's note, dated 7/27/23 at 9:00 A.M., indicated a "Behavior sheet made out on another resident that was rude to this resident. Resident removed from other resident immediately." A nurse's note, dated 7/27/23 at 9:10 A.M., indicated "This resident and her roommate are on a one hour checks when another resident in her room." During an interview on 7/26/23 at 10:13 A.M., Social Services Director indicated she talked to Resident 9 about roommate conflict. She indicated it is a conflict between roommates about several things. She spoke to Resident 9 yesterday about the conflict on the temperature in the room and they are working on a solution. During an interview on 7/28/23 at 2:40 P.M., LPN (Licensed Practical Nurse) 23 indicated Resident 9's roommate was moved to to a different room today. During an interview on 7/31/23 at 8:45 A.M., SSD indicated she had asked Resident 9 about moving rooms on 7/25/23 and she refused. When incident was discussed on 7/26/23, it was decided to move the roommate. During an interview on 8/01/23 at 12:24 P.M.,		concerns and or grievances and chart in a timely manner any concerns and or interventions. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Social Services Consultant will complete monthly audit for 6 months of the charting of SSD to ensure concerns and/or grievances are charted in a timely manner and or interventions are effective, for the 5 intellectual disabled residents and any new admissions who are deemed Intellectually Disabled. Social Services will continue to monitor residents' interactions with peers and/or roommates. Social Services will continue to monitor, and document reported concerns and or grievances and chart in a timely manner any concerns and or interventions. Audit records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. 9/13/23	

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	Resident 9 indicated roommate that moved to another room was still calling her names and cussing her out in the Common Area. She indicated she talked to Social Services. She indicated she wanted something done with previous roommate but she doesn't know what Social Services can do. A current, non-dated Social Services Director job description provided on 8/1/23 at 12:12 P.M., indicated "The Social Services Director is responsible for overseeing the development, implementation, supervision and ongoing evaluation of the Social Services Department designed to meet and assist residents in attaining or maintaining their highest practicable well-being...The Social Services Director will assist residents in voicing and obtaining resolution grievances. The Director will review complaints and grievances made by the resident and make a written report indicating what action (s) were taken to resolve the complaint or grievance..." 3.1-34(a)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% during a medication administration observation. The facility had a medication error rate of 5.41%. (Resident 11) Finding includes:	F 0759	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees,	09/15/2023

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	During an observation on 7/26/23 at 8:35 A.M., LPN 33 was preparing Resident 11's medications. Following preparation, LPN 33 administered 6 units of Humalog (insulin lispro) and Protonix (pantoprazole) 40 mg (milligrams) 1 tablet. During record review on 7/27/23 at 10:30 A.M., Resident 11's physician orders included, but were not limited to, Humalog (insulin lispro) 6 units at 7:00 A.M. before meals, and Protonix 40 mg 1 tablet at 7:00 A.M. before meals. During an interview on 7/27/23 at 11:00 A.M., the Dietary Manager indicated breakfast room trays are served between 7:30 - 8:00 A.M. During an interview on 7/27/23 at 11:20 A.M., LPN 23 indicated that Resident 11's 7:00 A.M. medication orders for Humalog and Protonix should be passed prior to the 8:00 A.M. medications to ensure the resident receives them before breakfast is served. LPN 23 indicated they have an hour window before and after the ordered administration time to give a medication. On 7/31/23 at 1:30 P.M., the facility administrator supplied an undated facility policy titled, Medication Administration Policy. The policy included, "...Medications are to be given one hour before to one hour after the administered time." 3.1-25(b)(9)		agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident # 11 no longer resides in the facility. 2. Identification of other residents having the potential to be affected was accomplished by: All residents receiving medications have the potential to be affected by this practice. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** Nurses and medication aides were in-serviced on preventing medication errors by the Director of Nursing Services. The Director of Nursing Services and/or designee observed medication administration for all nurses and medication aides on staff, individually, to ensure proper medication administration. A copy of the new orders will be given to the DON and/or designee who will review the record and MAR/TAR to ensure the orders match. The end of the month rewrite process will be second check to ensure the MAR and physician order sheet all match. **(Of note--***The facility has taken measures to help eliminate errors*	

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			going forward, by implementing an electronic charting system within the facility. The electronic charting system will help eliminate errors transcribing from place to place via handwriting. The electronic charting system will take approximately 3 to 4 months to be fully implemented but the facility began the installation process a few weeks ago.) **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing Services, or designee, will conduct an audit of 5 residents weekly for twelve (12) consecutive weeks, including any new admission, then 3 residents weekly for twelve (12) weeks, including any new admissions. These audits will ensure that the order was written according to the physician order and transcribed accurately on the MAR and physician order sheet. The Director of Nursing and designee will complete the monthly rewrites and follow up on new orders/progress notes matching the MAR/TAR. Any discrepancies will be clarified with the physician/NP. Audit results will be reviewed monthly by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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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
			Corrective action completion date: 9/15/23.	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure medications were stored properly for 2 of 2 medication carts and 2 of 2 medication storage rooms. Both medication carts contained loose medications and both medication storage room refrigerators lacked	F 0761	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault	09/15/2023

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	155270	A. BUILDING 00 B. WING	08/02/2023

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	daily temperature monitoring.(East Hall, West Hall) Findings include: 1. During an observation of the West Hall medication cart on 7/28/23 at 10:50 A.M., 1 loose capsule and 2 loose tablets were found in the 3rd drawer down. During an interview on 7/28/23 at 10:55 A.M., QMA 7 indicated the capsule was Depakote 125 mg (milligrams). QMA 7 was unable to identify the 2 tablets. QMA 7 indicated the carts should be cleaned and there should not be loose pills in the medication carts. 2. During an observation of the West Hall medication storage room on 7/28/23 at 11:00 A.M., a medication refrigerator containing resident insulin and suppositories had not been routinely checked to ensure the temperature was in range. A daily monitoring sheet for July had documentation that the refrigerator temperature was checked on 7/1/23, 7/2/23, 7/8/23, 7/9/23, 7/14/23, 7/15/23, 7/16/23, 7/20/23, 7/21/23, 7/22/23, and 7/23/23. 3. During an observation of the East Hall medication cart on 7/28/23 at 11:15 A.M., the second drawer down contained 1 and 1/2 loose tablets and 1 loose capsule. The third drawer down contained 1 loose whole tablet and 2 loose 1/2 tablets. The fourth drawer down contained 1 loose capsule and a loose 1/2 tablet. During an interview on 7/28/23 at 11:18 A.M., LPN 23 indicated one of the loose medications was Bumex. LPN 23 was unable to determine what the other loose medications were.		by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Both medication carts have been cleaned of loose medications in the bottom of the drawers. Both medication storage room refrigerators have temp logs and are now being checked appropriately. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents receiving medications requiring refrigeration have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** An in-service education was conducted by the Director of Nursing Services with staff nurses and medication aides on addressing the facility policy regarding the proper storage of medications and checking temperatures of the refrigerators in the medication storage rooms. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:**	

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	4. During an observation of the East Hall medication storage room on 7/28/23 at 11:20 A.M., a medication refrigerator containing resident insulin and suppositories had not been routinely checked to ensure the temperature was in range. The thermometer read 28 degrees. A daily monitoring sheet for July had documentation that the refrigerator temperature was checked on 7/1/23, 7/2/23, 7/8/23, 7/9/23, 7/14/23, 7/15/23, 7/16/23, 7/21/23, 7/22/23, and 7/23/23. On 7/28//23 at 12:00 A.M., the refrigerator temperature was documented at 30 degrees Fahrenheit (F) under the "TEMP # 1" column. No temperature was documented in the "TEMP # 2" column. The refrigerator temperatures record included, "Medication refrigerator temperature range is 35 - 40 degrees Fahrenheit... If temperature is out of range, adjust temperature and recheck in one hour until temperature within recommended range..." During an interview on 7/28/23 at 11:20 A.M., LPN 23 indicated that night shift nursing staff is supposed to check the medication storage room refrigerators temperatures and record the temperatures. LPN 23 indicated that there is supposed to be a night shift check list that tells staff when to clean out the medication carts. LPN 23 was unable to locate the check off task sheet and could not determine the last time the medication cart was cleaned out. During an interview on 7/28/23 at 11:30 A.M., the DON indicated staff should adjust the medication refrigerators temperature if it is out of range, then check it again an hour later. If the temperature is still out of range, the ADON or DON should be notified. On 7/31/23 at 1:30 P.M., the facility administrator		The Director of Nursing and/or designee will inspect all medication carts and refrigerators 5 x week for 8 weeks then 2 x week for 8 weeks and then 1 x week for 8 weeks to ensure temperature logs are completed and loose medications are disposed of properly. The pharmacy tech will inspect the carts 1 x a month ongoing for loose medications. This plan of correction will be monitored at the monthly Quality Assurance meeting until such a time consistent substantial compliance has been met. Corrective action completion date: 9/15/23.	

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	supplied an undated facility policy titled Medication Storage. The policy included, "It is the policy of this facility to ensure all medications housed on our premises will be stored in the medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. ...a All medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room. b. Temperatures are maintained within 36-46 degrees F. Charts are kept on each refrigerator and temperature levels are recorded daily by the charge nurse or other designee." 3.1-25(m)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and			

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	serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was stored in accordance with professional standards for food service safety during 2 of 2 kitchen observations. A reach in refrigerator contained a package of thawed ham was stored directly above refrigerated items, the reach in standing freezer was missing shelving and boxes of frozen food were stacked in a manner that did not allow proper air circulation, and the kitchen ceiling was in disrepair. Finding includes: During a kitchen observation on 7/24/23 at 8:30 A.M.: -a reach in refrigerator contained a box of thawed ham stored directly above a container of cottage cheese and various condiment bottles. -A reach in standing freezer was missing shelving and boxes of frozen food were stacked tightly from near the bottom of the freezer to near the top of the freezer. -An area of the ceiling above a space between the food prep area and the steam table appeared to have water damage, was discolored, and part of the ceiling was hanging down. During a kitchen observation on 7/26/23 at 11:00 A.M.: - a reach in refrigerator contained a box of thawed ham stored directly above a container of cottage cheese and various condiments. -A reach in standing freezer was missing shelving and boxes of frozen food were stacked tightly from near the bottom of the freezer to near the top of the freezer. -An area of the ceiling above a space between the	F 0812	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: The dietary manager immediately removed the meat and placed it on the bottom shelf. The shelves were out of the freezer for cleaning and have been placed back in the freezer. The ceiling has been repaired above the steam table. *2.* Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** All dietary staff have been in-service on the facility's policies and practice guidelines for maintaining refrigerator/freezer in proper order. Any noncompliance	09/15/2023

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	food prep area and the steam table appeared to have water damage, was discolored, and part of the ceiling was hanging down. During an interview on 7/26/23 at 12:00 P.M. the Dietary Manager (DM) indicated that meat should be stored on the bottom shelves not directly above other food items, that they needed shelving for the freezer so that boxes are not stacked directly on top of boxes, and that the roof had a leak that was repaired in the Spring of 2023, but that the ceiling had not yet been repaired. On 7/27/23 at 9:15 A.M., the DM supplied a facility policy titled Food Safety Requirements, dated 2/2023. The policy included, "...Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. ...Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident. Elements of the process include the following: ...Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms. ...Refrigerated storage... Practices to maintain safe refrigerated storage included: ...Separating raw foods... and storing raw meats on shelves below fruits, vegetables, and other ready-to-eat foods so that meat juices do not drip onto these foods." 3.1-21(i)(2) 3.1-21(i)(3)		in keeping the refrigerator according to professional standards will result in counseling's, up to and including termination. Maintenance has repaired the ceiling in the kitchen. The Administrator educated the maintenance staff regarding maintaining the building in good repair, timeliness of repairs and prioritizing repairs. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Dietary Manager or designee will complete 5 validation audits of the refrigerator and freezer 5 x week for 8 weeks, 3 validation audits a week for 8 weeks, and 1 validation audit a week for 8 weeks. Validation checklists will be reviewed by the Registered Dietitian, (RD) upon visits and brought to QA monthly for review. Maintenance Supervisor will round the building and log all repairs that need to be completed and items that need replaced. This log will then be used to prioritize the repairs/replacements to ensure they are completed in a timely manner. After the initial audit of repairs, the Maintenance Supervisor will round twice weekly	

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			for 6 months and ongoing to ensure there are no new repairs that need addressed. The audits will be discussed with the Administrator weekly to discuss the plans for the repairs and prioritize them. The audits will be part of an ongoing QA. This plan of correction will be monitored at the monthly Quality Assurance meeting until such a time consistent substantial compliance has been met. Corrective action completion date: 9/15/23.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing			

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

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	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were in place to prevent infection for 1 of 3 observations of resident care and during 2 random observations during the survey period. Staff failed to change gloves and perform hand hygiene when going from dirty to clean tasks during resident care, clean linens were transported uncovered, soiled linens and laundry were piled on a resident room floor, and the infection control program failed to document and/or follow facility infections from February 2023 thru April 2023. (Resident 36, West Hall) Findings include: 1. During a random observation on 7/26/23 at 1:06 P.M., laundry staff 25 was pushing a cart of clean linens down the West hall to be stored in a linen closet at the end of the hall. The linens were uncovered during transportation. On 8/1/23 at 10:35 A.M., the facility administrator supplied a facility policy titled, Handling Clean Linen, dated 6/2023. The policy included, "It is the policy of this facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which could lead to infection. ...Clean linens must	F 0880	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Laundry staff member #25 was immediately in-serviced on covering clean linen at all times during transport from laundry to linen closets. All nursing staff were in-serviced on donning and doffing gloves, handling linens/transport and peri care. An infection control program is in place with a certified Infection Preventionist nurse to oversee the	09/22/2023

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	be transported by methods that ensure cleanliness and protect from dust and soil during intra or inter-facility loading, transport and unloading, such as: a. Placing clean linen in a hamper lined with a previously unused liner, which is then closed or covered." 2. During a random observation on 7/28/23 at 7:42 A.M., a staff member was piling linens and clothing onto the floor of room 210 on the West Hall prior to putting them into a plastic bag. During an interview on 7/28/23 at 9:55 A.M., Laundry Staff 25 indicated laundry should not be put on the floor. Soiled laundry should be put directly into a bag and then into a laundry bin where laundry staff will pick it up. 3. During review of the facility's infection control program binder on 7/25/23 at 10:30 A.M., No documentation of infections, monitoring, inservices or education was included from February 2023 thru April 2023. During an interview on 7/25/23 at 9:45 A.M., the IP (Infection Preventionist) indicated that nothing had been done with the infection control program from January thru April of 2023. The IP started at the facility in June of 2023. 4. On 7/31/23 at 10:39 A.M., CNA (Certified Nurse Aide) 21 was observed to perform incontinence care for Resident 36. CNA 21 held 2 dry washcloths up against his shirt while he donned gloves before he entered the room. CNA 21 knocked on the door, opened it, and closed the door with his gloved hands. CNA 21 then pulled the curtain, moved the bedside table, touched the bed rail, touched the foot board, grabbed the remote to the bed off of the floor and lowered the bed with the same gloves. CNA 21 walked to the		program. Certified nursing assistant #21 was immediately in-serviced on proper hand hygiene procedures, handling dirty line and peri care. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** All nursing staff will be in-serviced on the facility's policy for hand hygiene, dirty linens, and peri care. In-service training includes observation of all staff performing hand hygiene procedures according to facility policy. Corrective action is provided as needed, up to and including termination. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Housekeeping/Laundry Supervisor will observe linen transport 2 x a day, 5 days a week for 8 weeks, 1 x a day, 4 days a week for 8 weeks, 1 x a day, 1 x a week for 8 weeks to ensure linens and/or clothing are covered during transport from	

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	bathroom and opened the door of the bathroom with his gloved hands and made the washcloths wet. Then, he sat the washcloths on top of the clean brief that was placed on top of the resident's blankets . CNA 21 unfastened Resident 36's brief, sat a washcloth on the bed, Resident 36 rolled to her left side and CNA 21 tucked the soiled brief under her buttocks and he placed a clean brief under the resident. The clean brief touched the soiled brief before the soiled brief was removed. Resident 36 rolled to her right side and CNA 21 removed the wet brief and placed it in the trash can and picked up the trash can with his gloved hand. CNA 21 placed the trash can near the bed and then obtained a wet washcloth and cleaned the resident with it. CNA 21 then fastened the brief, pulled the residents pants up, and touched the residents clothes with both gloved hands. At that time, he removed his left glove and closed the bathroom door. Then, he opened Resident 36's door and walked down the hallway to the shower room and disposed of bag that contained the brief. CNA 21 obtained hand sanitizer from his pocket and sanitized hands. CNA 21 failed to change gloves and wash hands from dirty to clean tasks. During an interview on 8/1/23 at 10:10 A.M., Staff 16 indicated that washcloths should not touch any clothing and they should be sat on a clean bedside table. At that time, she indicated hand hygiene should be performed between dirty and clean tasks. She indicated you should wash hands for 15 seconds when the gloves are soiled and after care is performed. On 8/1/23 at 10:34 A.M., the Administrator provided an undated Handling Clean Linen policy that indicated "...Carry clean linen with clean hands away from your body. Do not place clean		laundry to the linen closets or resident rooms. Any noncompliance will result in reeducation and/or counseling's up to and including termination. The Director of Nursing Services and/or the IP nurse will complete an audit of removing dirty linens from rooms: 3 rooms per day, 5 x a week for 8 weeks, 2 rooms per day, 4 x times a week for 8 weeks, 1 room per day, 2 x a week for 8 weeks. Any noncompliance will result in reeducation and/or counseling's up to and including termination. The Director of Nursing Services will audit the IC program binder monthly to ensure all infections, monitoring, in-services, or education are included in the program. Any noncompliance will result in reeducation of the IP nurse and or counseling's up to and including termination. The Director of Nursing Services and/or the IP nurse, will complete 3 random *Validation* Checklists a day, 5 x a week for 8 weeks, the 2 a day, 4 x a week, for 8 weeks and then 1x a day, 2 x a week x 8 weeks, to ensure staff are performing hand hygiene according to standards of practice for infection control. Any noncompliance will result in reeducation and/or counseling's up to and including termination.	

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	linen on the floor or other contaminated surfaces..." On 8/1/23 at 12:12 P.M., the Administrator provided an undated Personal Protective Equipment policy that indicated "Perform hand hygiene before donning gloves and after removal...Change gloves and perform hand hygiene between clean and dirty tasks, when moving from one body part to another, when heavily contaminated, or when torn..." On 8/1/23 at 12:12 P.M., the Administrator provided an undated Hand Hygiene policy that indicated "...This approach recommends health-care workers to clean their hands:...before touching a patient...after body fluid exposure/risk...after touching a patient...after touching patient surroundings...Direct caregivers must rub hands together vigorously, as follows. for AT LEAST 20 seconds, covering all surfaces of the hands and fingers..." 3.1-18(b)(1)(A) 3.1-18(l)		2 linen carts will be purchased for clean linens for C.n.a. use to distribute linens as needed. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met. Corrective action completion date :9/22/23	
F 0925 SS=E Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview, and record review, the facility failed to ensure resident spaces were free of pests during multiple random observations during the survey. Flies were observed in resident rooms and common resident areas landing on residents and on their personal items. (West Hall, East Hall, Resident C, Resident 1, Resident 36, Resident 23, Resident 31, Resident 8, Resident 19)	F 0925	Preparations or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth, on the statement of deficiencies. This plan of correction is prepared and executed solely because it is	09/15/2023

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	155270	A. BUILDING 00 B. WING	08/02/2023

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	Finding includes: During an interview on 8/1/23 at 9:00 A.M., Resident C stated, "these flies are horrible..." During an interview on 7/26/23 at 8:12 A.M., Resident 1 stated that the flies are getting to her. During an interview on 7/31/23 at 11:49 A.M., Resident 36 stated, "these damn flies." During the following observations, flies were in resident spaces: 7/24/23 at 10:18 A.M. - Resident G was sitting up in bed with multiple flies flying around his face. 7/24/23 at 10:47 A.M. - Resident 31 was siting up in a wheelchair with a fly flying around his face. 7/24/23 at 10:51 A.M. - Resident 8 was sleeping in his room with a fly on his leg. 7/26/23 at 8:12 A.M. - Resident 1 was sitting up in bed with a fly flying around her face. 7/26/23 at 8:33 A.M. - Resident 23 was lying in bed with a fly on her arm. 7/26/23 at 8:37 A.M. - Resident 36 was sitting up in bed eating breakfast while a fly was landing on her bed sheet. 7/28/23 at 1:20 P.M. - Resident 19 was laying in bed with his lunch tray next to him. Two flies were on his lunch tray. During an observation and interview on 7/31/23 at 12:50 P.M., an exterior door leading to an employee break area and the laundry building was measured to have a 1/4 inch gap near the base of the door where daylight could be seen. Maintenance 4 indicated that a resident had bent the bottom of the door and that they intended to have it replaced.		required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance. 1. Immediate action(s) taken for the room(s) found to have been affected include: A small fan specifically made to ward off flies was placed in Res # G room. A new commercial indoor Air Curtain was purchased and installed above the smoke area exit. Exit doors have weather striping installed to ensure cracks are filled. Pest control vendor is spraying every other week now instead of once a month. UV lightbulbs and adhesives in the fly light traps have been changed. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** An in-service was conducted by the Administrator with all maintenance staff. The in-service addressed the importance of identifying concerns with pests and finding root cause of problem areas and fixing immediately. A checklist was given to maintenance staff to use to check	

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	During an interview on 7/31/23 at 1:00 P.M. the Maintenance Supervisor indicated that most of the flies in the building come from the exit door to the smoking area from residents constantly going in and out. During an observation and interview on 7/31/23 at 1:05 P.M., the main entrance door was measured to have a 3/8 inch gap base of the door where daylight could be seen through the gap. Maintenance 4 indicated that the building has settled causing the door to be out of square. There were no current plans to have the main entrance door repaired. On 8/1/23 at 10:35 A.M., the facility administrator supplied a facility policy titled, Resident Environmental Quality, dated 7/2022. The policy included, "It is the policy of this facility to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. ...The facility shall: ...Maintain an effective pest control program so the facility is free of pests and rodents." 3.1-19(a)(4) 3.1-19(f)		areas where pests can be attracted to and ensure areas such as trash dumpsters and waste cans are inspected for food etc are cleaned up. We have 2 pest control vendors. Ecolab has installed fly traps beside the smoke exit door as well as by the kitchen door. B & B spray bi-weekly around the outside of the building, at doorways, around windows as well as the inside for part of the pest control program. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** Maintenance Pest control records and checklists will be reviewed by the Administrator with the Maintenance Supervisor weekly, for 6 months to ensure vendors are coming in taking care of any pest concerns. Any concerns identified will be rectified immediately. Maintenance Supervisor and/or designee will round 5 rooms weekly on each unit to ensure the measures put into place are effective through the end of November and then annually April through November for continued compliance with pest control. This plan of correction will be monitored at the monthly Quality Assurance meeting for 6 months or until such time consistent substantial compliance has been met.	

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			Corrective action completion date:.9/15/23	
F 0940 SS=E Bldg. 00	483.95 Training Requirements §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- Based on interview and record review, the facility failed to develop, implement, and maintain an effective training program for all contractual staff consistent with their expected roles. The facility failed to develop a program and provide inservices to agency staff prior to working in the facility during all days of the survey. Findings include: On 7/29/23 on day shift, 4 of 4 direct resident care staff (RN, LPN, 2-CNA) were agency that were not aware of an Immediate Jeopardy and had not received any inservices prior to the shift. The Administrator identified the four contracted staff were considered independent contractors which worked through (name of agency) an online staffing company. We post the open shift and someone fills it. We do not know who is going to work until they show up, sometimes it is a person who has been here before. During an interview on 8/1/23 at 12:46 P.M., the	F 0940	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: The facility policy was updated to include contracted staff and volunteers in the training programs. Any current trainings contracted staff and volunteers have completed will be copied to ensure	09/15/2023

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	Administrator indicated agency staff did not receive any inservices prior to working in the facility. Agency staff was required to do inservices through their agency, but she was unaware of which inservices agency staff received. During an interview on 8/1/23 at 12:50 P.M., Agency CNA (Certified Nurse Aide) 18 indicated she worked in the facility about a year and had not received any inservices from the facility. During an interview on 8/2/23 at 8:32 A.M., Social Services (SS) indicated agency staff was not required to complete any inservices prior to working in the facility, and they will have to decide how to implement inservices for agency staff. During an interview on 8/2/23 at 9:29 A.M., the DON (Director of Nursing) indicated the policy provided "continuing education" was for facility staff only and did not include agency staff. At that time, she indicated they did not have a policy for agency staff inservicing. It is assumed that agency staff completed the required inservicing through their own agency prior to working at the facility, but she did not know how to obtain that information. No contract for staffing agency was provided. On 8/2/23 at 12:00 P.M., the Administrator provided inservices obtained by 2 agency CNA's. Both CNA's inservices lacked what date the inservices were completed. On 8/2/23 at 9:29 A.M., the DON provided an undated Continuing Education policy that indicated "...It is the responsibility of each employee to complete required training..."		that the facility has on file, prior to working. All training submitted must be completed within the current year. Any training not completed, will be expected to be completed prior to working the shift that is located in the training binder labeled Agency Staffing. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** All staff were in-serviced regarding the facility policy for training requirements and the expectation of attendance/completion. The in-service was added to the contracted staff binders for signatures. Memos' were placed at the front lobby, the schedule board as well as each unit to ensure contracted staff and volunteers are aware of the training binders and expectations of trainings. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON and/or ADON will complete 5 weekly audits for 8 weeks then 3 weekly audits for 8 weeks then 1 weekly audit for 8 weeks to ensure compliance.	

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	3.1-13(b)(2)		Any noncompliance will result in verbal warning up to and including termination of individual contracts and a DNR (do not return) from facility management. Audit records will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	
F 9999 Bldg. 00	7-4 Staff training and development programs Sec. 3. (a) Each facility shall provide in service training and shall require all staff working with 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 to all staff working with developmentally disabled residents concerning their developmental disabilities. Specific in services were not provided concerning the 5 residents diagnosed with intellectual developmental disabilities. Findings include: On 8/1/23 at 12:10 P.M., the Resident Census and Condition form was reviewed and indicated 5	F 9999	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: A Policy and Procedure for Developmentally Disabled Individuals was created and implemented. Implementation of the policy was in part by developing habilitation plans for the 5 residents diagnosed with intellectual	09/08/2023

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	residents with intellectual and/or developmental disability. On 8/1/23 at 1:53 P.M., an in-service training record sign in sheet was provided, dated 5/19/23. The topics listed for the training included mental and psychosocial disorders, intellectual disorders, bipolar, schizophrenia, misc. reminders, and nurses/QMAs (Qualified Medication Aide) - narcotic policy and procedure and diversion. The form was signed by 20 staff members, across all departments. On 8/1/23 at 1:38 P.M., the Social Services Director (SSD) indicated she had held one in-service related to intellectual and/or developmental disabilities, but the goal was to hold one every 3 months. On 8/2/23 at 7:04 A.M., the Director of Nursing (DON) indicated the names listed on the in-service training record were not all staff. On 8/2/23 at 8:20 A.M., the employee records form was compared to the sign in sheet from 5/19/23 and showed 23 employees who were employed at the time of the in-service had not signed the sign in sheet. 7-4 Resident programs Sec. 4. (a) The facility shall provide a program for developmentally disabled individuals, which assures the following: (2) The designated staff member is responsible for the development and implementation of the habilitation program which shall include an assessment of need for community services and a care habilitation plan based upon a diagnostic screening.		developmental disabilities currently at the facility. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents with developmental disabilities have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** Social Services will in-service all staff working with the developmentally disabled individuals within the facility with an Introduction to Intellectual Disabilities on 8/25/23. Social Services will provide in-services quarterly to all staff related to developmental disabilities, Psychosocial Disorders, Substance Abuse, and Trauma. Social Services provided the in service used for training current staff, in the new hire orientation packets as well as the contracted staff binders. All newly admitted residents with a developmental disability will have a habilitation plan implemented within 5 days of admission and reviewed quarterly with the MDS schedule. **4. How the corrective**	

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	This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement a written program for the 5 developmentally disabled residents residing in the facility with intellectual developmental disabilities. Findings include: On 8/1/23 at 12:10 P.M., the Resident Census and Condition form was reviewed and indicated 5 residents with intellectual and/or developmental disability. On 8/1/23 at 1:34 P.M., the Administrator indicated the facility's QIDP (qualified intellectual disabilities professional) was the Social Services Director (SSD), but a consultant also came to the facility monthly to assist with the program. On 8/2/23 at 8:29 A.M., the SSD indicated as of right now, the facility did not have a written program outline or policy related to providing for residents with an intellectual disability or developmental delay. She indicated the only policy was the one related to in-servicing for the program. The QIDP consultant was coming once a month and she had been doing the care plan maintenance, as well as the notes in the resident charts. She indicated she had implemented a shelter workshop, and was currently working on that. She also indicated she was unaware that the facility required a written program to include habilitation plans and a policy related to the program. On 8/1/23 at 1:53 P.M., a current Competent Staff Behavioral Health Needs Training policy, dated		**action(s) will be monitored to ensure the practice will not recur:** All newly admitted residents with a developmental disability will have a habilitation plan implemented within 5 days of admission and reviewed quarterly. The IDT team will review the habilitation plan and sign off initially and quarterly with the MDS schedule. Social Service Director and/or designee will review PSARR's to determine if any other individuals have a developmental disability and need a habilitation plan. Audit records will be reviewed monthly by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion **date 9/8/23**	

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	9/15/21, was provided and indicated "It is the policy of [name of facility] to provide appropriate competencies and skills to ensure residents safety and maintain the highest physical, mental, and psychosocial well-being of each resident. Staff will complete the competencies prior to working the floor on Mental and Psychological Disorders. Each year all staff will receive training on the four Competencies (Psychological Disorders, Substance Abuse, Trauma, and Intellectual Disorders) determined by resident assessments and the diagnoses of the facility's resident population. These competencies will provide the skills and knowledge needed for staff to care for residents who have mental and psychosocial disorders"			