| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155695 | A. BUILDING 00<br>B. WING | 12/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| RIVERSIDE VILLAGE | 1400 W FRANKLIN ST<br>ELKHART, IN 46516 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00422308.<br><br>Complaint IN00422308 - No deficiencies related to the allegations are cited.<br><br>Survey dates: December 5, 6, 7, 8, 11, and 12, 2023<br><br>Facility number: 003075<br>Provider number: 155695<br>AIM number: 200364160<br><br>Census Bed Type:<br>SNF/NF: 79<br>Total: 79<br><br>Census Payor Type:<br>Medicare: 2<br>Medicaid: 62<br>Other: 3<br>Total: 79<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on 12/22/23. | F 0000 | **F000**<br>Preparation and/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 in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully requests a desk review due to the low scope and severity of the deficiencies noted. | |
| F 0600<br>SS=D<br>Bldg. 00 | 483.12(a)(1)<br>Free from Abuse and Neglect<br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>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, | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Greg Schiavone | | 01/12/2024 |

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

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| | involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>Based on interview and record review, the facility failed to prevent verbal abuse from occurring for 2 of 3 residents reviewed for abuse. (Residents 32 and 45)<br><br>Finding includes:<br><br>During an interview on 12/5/2023 at 9:38 A.M., Resident 32 indicated that the facility was allowing Resident 45 to engage in verbal violence. She indicated the last occurrence was 3 days ago on 12/2/2023. Resident 45 called her a pig and other names while in the dining room at an adjacent table when the incident occurred. Resident 32 indicated the facility allowed the verbally aggressive resident to sit at the table next to her. She shouldn't have to feel afraid, and feels bad about Resident 45 laughing at her. Resident 32 indicated the "guy in the office" won't do anything about the issue.<br><br>During an interview on 12/6/2023 at 9:45 A.M., Resident 53 indicated that two ladies got into an argument in the dining room, and he intervened verbally. Residents 32 and 45 were involved. He indicated these verbal issues happened frequently between the two residents and no staff intervened in this incident until he became verbal.<br><br>On 12/6/2023 at 11:52 A.M., a conversation could be heard with Resident 32 and the Administrator | F 0600 | **F600**<br>**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br><br>Residents 32 and 45 were affected by this practice. Both residents have received psychosocial follow up with no issues noted.<br><br>**how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br><br>All residents have the potential to be affected. A review of all reportable incidents revealed no other issues. Other residents were interviewed using abuse QIS questions to determine if any other residents have experienced verbal abuse.<br><br>**what measures will be put into place and what** | 01/19/2024 |

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| | in the hallway, with Resident 32 asking the administrator about the incident that occurred on 12/2/2023 in the dining room.<br><br>A record review for Resident 32 was completed on 12/07/2023 at 2:08 P.M. Diagnoses included, but were not limited to: schizoaffective disorder, delusional disorder, and intellectual disabilities.<br><br>A Significant Change Minimum Data Set (MDS) assessment, dated 10/27/2023, indicated Resident 32 was cognitively intact, and had no behaviors during the assessment period.<br><br>A Progress Note for Resident 32, dated 12/6/2023 at 12:01 P.M., indicated, " ...Notified that resident reported hearing co-resident yelling in main dining area, not at her, but in general vicinity, and did not like statements yelled. Resident reports no psychosocial distress at this time with writer. Will continue to observe. Notified guardian, no questions or concerns at this time ...."<br><br>A Care Plan, initiated 6/14/2021 and revised on 10/31/2023, indicated Resident 32 had been observed yelling at another resident after being yelled at by that resident.<br><br>A record review for Resident 45 was completed on 12/11/2023 at 1:54 P.M. Diagnoses included, but were not limited to: cerebral infarction, vascular dementia, adjustment disorder with mixed anxiety and depressed mood.<br><br>A Quarterly MDS assessment, dated 12/5/2023, indicated Resident 45 had moderate cognitive impairment and had verbal behavioral symptoms direct towards others for 2-6 days of the assessment period. | | **systemic changes will be made to ensure that the deficient practice does not recur;**<br><br>All staff have been inserviced on or before 1/19/24 on preventing and reporting incidents of abuse. The Executive Director has been educated on Resident to resident abuse protocol.<br>Residents to be interviewed weekly x4 using abuse questionnaires to determine if any verbal abuse has occurred.<br><br>**• how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and**<br><br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Resident to Resident Abuse” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up | |

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| | A Nurse's Note, dated 12/2/2023 at 6:00 P.M., indicated Resident 45 was sitting at a table in the dining room talking to another resident. Resident 45 started yelling and swearing at a second resident (Resident 32) sitting at another table, and then at a third resident (Resident 53) sitting at a different table after a comment was made by the third Resident to staff. Resident 45 was assisted out of the dining room and put on 15-minute safety checks.<br><br>On 12/4/2023 at 10:17 A.M., an Interdisciplinary Team Behavior Note indicated Resident 45 started swearing and yelling at two residents.<br><br>A Care plan, initiated on 7/9/2023 and updated 12/6/2023, indicated Resident 45 would make comments that may become offensive to others, and may make threatening statements towards staff and other residents.<br><br>A Psychiatry Progress Note, dated 11/9/2023, indicated, " ...Patient with continued episodes of antagonizing other residents and staff. She continues to get into verbal alterations. She is somewhat redirectable ...."<br><br>During an interview on 12/11/2023 at 10:00 A.M., LPN 5 indicated she didn't witness the interaction, but QMA 7 informed her of the incident and separated Residents 32 and 45. LPN 5 indicated she was aware of the verbal altercation, and believed the incident was verbal abuse. She indicated LPN 6 notified the Director of Nursing and Administrator of the abuse.<br><br>On 12/11/2023 at 2:44 P.M., QMA 7 indicated she was standing in the doorway of the dining room watching everyone, and heard Resident 45 say something, then Resident 32 said something back | | | |

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| | to Resident 45. She indicated she knew the residents were arguing and Resident 45 called Resident 32 "a fat b*tch". QMA 7 indicated she felt this was verbal abuse.<br><br>On 12/12/2023 at 10:15 A.M., LPN 6 indicated she was not in the dining room at the time of the incident, but Resident 45 called Resident 32 "a stupid b*tch". Resident 53 made a comment about getting the two residents out of the dining room. The Director of Nursing and Administrator were informed of the incident, and the Administrator talked to Resident 45.<br><br>On 12/12/2023 at 11:55 A.M., the Administrator indicated Resident 32 came to him and told him of statements that made her uncomfortable, but didn't indicate which resident made the comments. He remembers the staff contacting him about Resident 45 being upset at the nurse's station, but no mention of the incident in the dining room.<br><br>On 12/12/2023 at 12:01 P.M., the Director of Nursing indicated Resident 32 reported that Resident 45 was yelling at her, and she informed the Administrator about the incident. She remembered getting a telephone call about Resident 45 being upset with staff and other residents, but could not recall being informed of the dining room incident.<br><br>A policy titled, "Abuse Prohibition, Reporting, and Investigating" was provided by the Administrator after the entrance conference. The policy indicated, " ...Policy: It is the policy of [Facility Corporation Name] to provide each resident with an environment that is free from abuse, neglect, misappropriation of property, and exploitation. This includes, but is not limited to verbal abuse, sexual abuse, physical abuse, | | | |

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| | mental abuse, corporal punishment, and involuntary seclusion ...[Facility Corporation Name] will not permit residents to be subjected to abuse by anyone including employees, home office staff, other residents, consultants, volunteers, staff, or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends, or other individuals ...Definitions/Examples of Abuse: ...Verbal Abuse - The use of oral, written, and/or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within hearing distance, regardless of their age, ability to comprehend, or disability. This includes any episode of staff to resident, and verbal threats of harm by resident to resident. This does not include random statements of a cognitively impaired resident such as repetitive name calling or nonsensical language ...."<br><br>3.1-27(b) | | | |
| F 0609<br>SS=D<br>Bldg. 00 | 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br>Reporting of Alleged Violations<br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the | | | |

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| | administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>Based on interview and record review, the facility failed to report an allegation of verbal abuse timely for 2 of 3 residents reviewed for abuse. (Residents 32 and 45)<br><br>Finding includes:<br><br>Cross Reference F600.<br><br>During an interview on 12/5/2023 at 9:38 A.M., Resident 32 indicated that the facility was allowing Resident 45 to engage in verbal violence. She indicated the last occurrence was about 3 days ago. Resident 45 called her a pig and other names while in the dining room at an adjacent table when the incident occurred. Resident 32 indicated the facility allowed the verbally aggressive resident to sit at the table next to her. She shouldn't have to feel afraid, and feels bad about Resident 45 laughing at her. Resident 32 indicated the "guy in the office" won't do anything about the issue.<br><br>During an interview on 12/6/2023 at 9:45 A.M., Resident 53 indicated two ladies got into an | F 0609 | **F609**<br>**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br><br>Residents 32 and 45 were affected by this practice. Both residents have received psychosocial follow up with no issues noted.<br><br>**how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br><br>All residents have the potential to be affected. A review of all reportable incidents revealed no other issues. Completed review of psychosocial follow up and | 01/19/2024 |

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| | argument in the dining room, and he intervened verbally. He indicated Residents 32 and 45 were involved. He indicated these verbal issues happened frequently between the two residents. He indicated no staff intervened in this incident until he became verbal.<br><br>A record review for Resident 32 was completed on 12/7/2023 at 2:08 P.M. Diagnoses included, but were not limited to: schizoaffective disorder, delusional disorder, and intellectual disabilities.<br><br>A Significant Change Minimum Data Set (MDS) assessment, dated 10/27/2023, indicated Resident 32 was cognitively intact, and had no behaviors during the assessment period.<br><br>On 12/6/2023 at 11:52 A.M., a conversation could be heard with Resident 32 and the Administrator in the hallway outside the provide room for the surveyors with Resident 32 asking the administrator about the incident that occurred on 12/2/2023 in the dining room.<br><br>A Progress Note for Resident 32, dated 12/6/2023 at 12:01 P.M., indicated, " ...Notified that resident reported hearing co-resident yelling in main dining area, not at her, but in general vicinity, and did not like statements yelled. Resident reports no psychosocial distress at this time with writer. Will continue to observe. Notified guardian, no questions or concerns at this time ...."<br><br>A Care Plan, initiated 6/14/2021 and revised on 10/31/2023, indicated Resident 32 has been observed yelling at another resident after being yelled at by that resident.<br><br>A record review for Resident 45 was completed on 12/11/2023 at 1:54 P.M. Diagnoses included, but | | behavior care plans to ensure follow up and interventions in place for reportable incidents.<br><br>**what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**<br><br>All staff have been inserviced on or before 1/19/24 on reportable incidents and abuse. The Executive Director has been educated on reporting abuse. Review of behavior management documents to be completed by IDT to determine if further investigation is warranted.<br><br>**• how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and**<br><br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Reportable File” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan | |

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| | were not limited to: cerebral infarction, vascular dementia, adjustment disorder with mixed anxiety and depressed mood.<br><br>A Quarterly MDS assessment, dated 12/5/2023, indicated Resident 45 had moderate cognitive impairment and had verbal behavioral symptoms direct towards others for 2-6 days of the assessment period.<br><br>A Nurse's Note, on 12/2/2023 at 6:00 P.M., indicated that Resident 45 was sitting at a table in the dining room talking to another resident. Resident 45 started yelling and swearing at a second resident (Resident 32) sitting at another table, and then at a third resident (Resident 53) sitting at a different table after a comment was made by the third Resident to staff. Resident 45 was assisted out of the dining room, and put on 15-minute safety checks.<br><br>On 12/4/2023 at 10:17 A.M., an Interdisciplinary Team Behavior Note indicated Resident 45 started swearing and yelling at two residents.<br><br>A Care plan, initiated on 7/9/2023 and updated 12/6/2023, indicated that Resident 45 will make comments that may become offensive to others, and may make threatening statements towards staff and other residents.<br><br>A Psychiatry Progress Note dated 11/9/2023, indicated, " ...Patient with continued episodes of antagonizing other residents and staff. She continues to get into verbal alterations. She is somewhat redirectable ...."<br><br>During an interview on 12/11/2023 at 10:00 A.M., LPN 5 indicated she didn't witness the interaction, but QMA 7 informed her of the incident and | | will be developed. Findings will be submitted to the QAPI Committee for review and follow up | |

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| | separated Residents 32 and 45. LPN 5 indicated she was aware of the verbal altercation, and believed the incident was verbal abuse. She indicated LPN 6 notified the Director of Nursing and Administrator of the abuse.<br><br>On 12/12/2023 at 10:15 A.M., LPN 6 indicated she was not in the dining room at the time of the incident, but Resident 45 called Resident 32 "a stupid bitch". Resident 53 made a comment about getting the two residents out of the dining room. She indicated the Director of Nursing and Administrator was informed of the incident, and the Administrator talked to Resident 45.<br><br>The state reportable was requested on 12/12/2023 at 11:48 A.M. The incident, reported on 12/6/2023 at 11:45 A.M., indicated Resident 32 reported to the Administrator that she felt uneasy about statements in the dining room by another resident. The report indicated the statements were made at an unspecified time and date. The report indicated an investigation into the claim was initiated, the residents to be separated during mealtimes and activities, social service to follow up, and staff to follow for psychosocial wellbeing.<br><br>On 12/12/2023 at 11:55 A.M., the Administrator indicated Resident 32 came to him and told him of statements that made her uncomfortable, and didn't indicate who the resident was that made the comments. He indicated he remembers the staff contacting him about Resident 45 being upset at the nurse's station, but no mention of the incident in the dining room.<br><br>On 12/12/2023 at 12:01 P.M., the Director of Nursing indicated the Resident 32 reported Resident 45 was yelling at her and she informed the Administrator about the incident. She | | | |

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| | indicated she remembered getting a telephone call about Resident 45 being upset with staff and other residents, but could not recall being informed of the dining room incident.<br><br>A policy titled, "Abuse Prohibition, Reporting, and Investigating" was provided by the Administrator after the entrance conference. The policy indicated, " ...Reporting/Response: 1. All abuse allegations must be reported to the executive Director immediately. Failure to report will result in disciplinary action, up to and including immediate termination. 2. The Executive Director will ensure that if the alleged violation involves abuse or results in serious bodily injury, it must be reported immediately but no later than 2 hours to the Long-term Care Division of the Indiana State Department of Health via the Gateway Portal ...."<br><br>3.1-28(c) | | | |
| F 0610 SS=D Bldg. 00 | 483.12(c)(2)-(4)<br>Investigate/Prevent/Correct Alleged Violation<br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within | | | |

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| | 155695 | A. BUILDING 00<br>B. WING | 12/12/2023 |

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| | 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>Based on interview and record review, the facility failed to thoroughly investigate an allegation of resident to resident verbal abuse for 2 of 3 residents reviewed for abuse. (Residents 32 and 45)<br><br>Finding includes:<br><br>Cross reference F600.<br><br>During an interview on 12/5/2023 at 9:38 A.M., Resident 32 indicated that the facility was allowing Resident 45 to engage in verbal violence. She indicated the last occurrence was 3 days ago on 12/2/2023. Resident 45 called her a pig and other names while in the dining room at an adjacent table when the incident occurred. Resident 32 indicated the facility allowed the verbally aggressive resident to sit at the table next to her. She shouldn't have to feel afraid, and feels bad about Resident 45 laughing at her. Resident 32 indicated the "guy in the office" won't do anything about the issue.<br><br>On 12/6/2023 at 9:45 A.M., Resident 53 indicated two ladies got into an argument in the dining room, and he intervened verbally. He indicated Residents 32 and 45 were involved. He indicated these verbal issues happen frequently between the two residents. He indicated no staff intervened in this incident until he became verbal.<br><br>A record review for Resident 32 was completed on 12/07/2023 at 2:08 P.M. Diagnoses included, but were not limited to: schizoaffective disorder, delusional disorder, and intellectual disabilities. | F 0610 | **F610**<br>**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br><br>Residents 32 and 45 were affected by this practice. Both residents have received psychosocial follow up with no issues noted. Event of verbal abuse which occurred on 12/2/23 has been thoroughly investigated.<br><br>**how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br><br>All residents have the potential to be affected. A review of all reportable incidents revealed no other issues and were reviewed to determine if a thorough investigation was completed.<br><br>**what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**<br><br>All staff have been inserviced on or | 01/19/2024 |

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| | A Significant Change Minimum Data Set (MDS) assessment dated 10/27/2023, indicated Resident 32 was cognitively intact, and had no behaviors during the assessment period.<br><br>On 12/6/2023 at 11:52 A.M., a conversation could be heard with Resident 32 and the Administrator in the hallway outside the provide room for the surveyors with Resident 32 asking the administrator about the incident that occurred on 12/2/2023 in the dining room.<br><br>A Progress Note for Resident 32, dated 12/6/2023 at 12:01 P.M., indicated, " ...Notified that resident reported hearing co-resident yelling in main dining area, not at her, but in general vicinity, and did not like statements yelled. Resident reports no psychosocial distress at this time with writer. Will continue to observe. Notified guardian, no questions or concerns at this time ...."<br><br>A Care Plan initiated 6/14/2021, and revised on 10/31/2023, indicated that Resident 32 has been observed yelling at another resident after being yelled at by the other resident.<br><br>A record review for Resident 45 was completed on 12/11/2023 at 1:54 P.M. Diagnoses included, but were not limited to: cerebral infarction, vascular dementia, adjustment disorder with mixed anxiety and depressed mood.<br><br>A Quarterly MDS assessment, dated 12/5/2023, indicated Resident 45 had moderate cognitive impairment and had verbal behavioral symptoms direct towards others for 2-6 days of the assessment period.<br><br>A Nurse's Note, dated 12/2/2023 at 6:00 P.M., indicated Resident 45 was sitting at a table in the | | before 1/19/24 on reportable incidents and abuse. The Executive Director has been educated on reportable incident investigation and completion of a thorough investigation. All allegations of abuse will be reviewed by IDT to determine if a thorough investigation was completed per protocol.<br><br>**• how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and**<br><br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The ED/designee will be responsible for completing the QAPI Audit tool “Abuse Prohibition and Investigation” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up | |

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| | dining room talking to another resident. Resident 45 started yelling and swearing at a second resident (Resident 32) sitting at another table, and then at a third resident (Resident 53) sitting at a different table after a comment was made by the third Resident to staff. Resident 45 was assisted out of the dining room, and put on 15-minute safety checks.<br>On 12/4/2023 at 10:17 A.M., an Interdisciplinary Team Behavior Note indicated Resident 45 started swearing and yelling at two residents.<br><br>On 12/11/2023 at 2:44 P.M., QMA 7 indicated she was standing in the doorway of the dining room watching everyone, and heard Resident 45 say something, then Resident 32 said something back Resident 45. She indicated she knew the residents were arguing and Resident 45 called Resident 32 "a fat bitch". QMA 7 indicated she felt this was verbal abuse.<br><br>The state reportable was requested on 12/12/2023 at 11:48 A.M. The incident, reported on 12/6/2023 at 11:45 A.M., indicated Resident 32 reported to the Administrator that she felt uneasy about statements in the dining room by another resident. The report indicated the statements were made at an unspecified time and date. The report indicated an investigation into the claim was initiated, the residents to be separated during mealtimes and activities, social service to follow up, and staff to follow for psychosocial wellbeing.<br><br>Review of the facility investigation on 12/12/23, indicated only three staff members were interviewed but not the staff member who had initially witnessed the incident. No resident interviews were included, including the 2 residents involved. | | | |

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| | On 12/12/2023 at 11:55 A.M., the Administrator indicated that Resident 32 came to him and told him of statements that made her uncomfortable, and didn't indicate who the resident was that made the comments. He indicated he remembers the staff contacting him about Resident 45 being upset at the nurse's station, but no mention of the incident in the dining room. He indicated he had not further interviewed Resident 32 about the incident. Only 3 employee interviews were completed.<br><br>A policy titled, "Abuse Prohibition, Reporting, and Investigating" was provided by the Administrator after the entrance conference. The policy indicated, " ...The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed. In the absence of the Executive Director, the responsibility will be delegated to the Director of Nursing Services ...1. Any individual who witnesses resident-to-resident abuse will immediately separate and protect the residents involved. 2. Staff member(s) will maintain the resident initiating the abuse under direct supervision until the initial investigation is complete and resident safety is maintained ...4. The staff member in charge will initiate the investigation immediately. 5. The Executive Director will be notified immediately of the report and the initiation of the investigation ...16. The Executive Director/Designee will analyze the occurrence to determine root cause, and what changes are needed to prevent further occurrence and report to the QAPI [Quality Assurance and Performance Improvement] committee. 17. Based on the root cause, ED [Executive Director]/Designee will determine how care | | | |

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| | provision will be changed ...."<br><br>3.1-28(d) | | | |
| F 0656<br>SS=D<br>Bldg. 00 | 483.21(b)(1)(3)<br>Develop/Implement Comprehensive Care Plan<br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(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)(6).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for | | | |

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| | 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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>Based on observation, record review, and interview, the facility failed to ensure a care plan regarding activities was individualized and based on resident assessment for 1 of 18 residents whose care plans were reviewed. (Resident 21)<br><br>Finding includes:<br><br>The clinical record for Resident 21 was reviewed on 12/06/2023 at 3:45 P.M. The resident was admitted to the facility with diagnoses including, but not limited to: hemiplegia/hemiparesis following a cerebral infarction, encephalopathy, severe protein calorie malnutrition, dysphagia, aphasia, major depressive disorder, recurrent, anxiety disorder, chronic pain, gastrostomy, insomnia, adult failure to thrive, mitral valve insufficiency, emphysema and kidney stones.<br><br>On 12/06/2023 at 11:15 A.M., Resident 21 was observed lying in bed with the head of the bed slightly elevated. Resident 21 indicated he just "lays there and does nothing." When asked what he liked to do before he entered the facility, he indicated he never liked to be around a lot of people, but enjoyed fishing at the river and being | F 0656 | **F656**<br>**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**<br><br>Residents 21 was affected by this practice. Staff has reviewed the specific care plan with this resident and individualized the care plan to meet the resident activity needs.<br><br>**how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**<br><br>All residents have the potential to be affected. An audit of all activities care plans was completed to ensure the care | 01/19/2024 |

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| | outside. He never really watched a lot of television.<br><br>On 12/07/23 at 11:17 A.M., Resident 21 was observed lying in his bed awake. There was no television or radio noted on the his side of the room. The blind to the window was 2/3 of the way closed. He indicated sometimes there were squirrels outside that ran along a fence near his window that he enjoyed watching. When asked if he had been out of bed, he indicated yesterday the therapist who was working on his motorized wheelchair had gotten him out of bed briefly.<br><br>On 12/8/2023 at 10:50 A.M., Resident 21 was observed lying in his bed awake. The resident had just received medications. The window blind was again 2/3 of the way closed. The resident again mentioned the squirrel that sometimes ran along the fence outside his window. He indicated the therapy department was adapting his power chair for him and he had not gotten out of bed recently, except briefly with the therapy department. Resident 21 indicated he really enjoyed listening to country music, especially Conway Twitty. When asked if he had a radio in the room, he indicated at home he had a stereo, record player and DVD player, but it was at his daughter's house.<br><br>On 12/11/2023 at 10:20 A.M., Resident 21 was observed lying in his bed awake. He indicated he did not currently have a phone, radio, television or record player in his room. He was not sure where he could plug in the equipment if they were in his room. There were all types of clothing, personal hygiene care items and other medical care equipment noted to be covering the seat of a manual wheelchair, the top of a personal sized refrigerator, the window sill and the top of the | | plans were individualized for activities. Any concerns identified will be addressed immediately.<br><br>**what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**<br><br>An in-service with the Activities Director on Care Plan policies and procedures was completed on or before 1/19/24. Activities Director will review all new admissions to ensure accurate activities care plans are present and individualized.<br><br>**how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and**<br><br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Activity Director/designee will be responsible for completing the QAPI Audit tool “Care plan Review” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be | |

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| | three drawer dresser. There was only a Styrofoam cup with a straw on his overbid table. There was no books, puzzles, newspapers and/or magazines noted in his room.<br><br>The Annual MDS (Minimum Data Set) assessment, completed on 6/7/2023, indicated it was very important to him to listen to music he liked, very important to do his favorite activities and go outside. The assessment indicated it was somewhat important to have books, newspapers, keep up with the news, and have pet visits.<br><br>The current care plan, last reviewed related to activities on 11/2/2023, indicated the following: "Problem: Resident enjoys independent activity pursuits such as watching tv visits from his daughter...<br>Goal: Resident will participate in independent activities to their level of satisfaction and will be open to alternative programming...<br>Approach(s) Encourage daily socialization outside of room...Encourage participation in scheduled programming... Offer items for room (Books, magazines, puzzles)"<br><br>During an interview with the Activity Director on 12/08/23 at 12:40 P.M., she agreed the resident spent most of his time in his room in bed, but did come out with his daughter at times. He was seen 1:1 by the activity assistants, but sometimes refused. When asked about the music, she indicated he refused to come to music programs. When asked about individualizing his care plan she indicated he watches TV on his phone. She indicated he had been out of his room earlier this week on a motorized wheelchair with the therapy department. When asked about the puzzles, books and magazines, she indicated she was not sure what was provided to him or where it was | | submitted to the QAPI Committee for review and follow up | |

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| | located. When the discrepancies between the MDS assessment preferences section, the current activity care plan and observations of Resident 21 were brought to her attention, the activity director stated "I know you can't force them to go (to group activities) even though you really want to make them." She indicated it seems like recently a lot of residents being admitted did not desire to go to activities with groups. The activity director offered no explanation as to why the care plan for Resident 21 did not reflect his individualized preferences.<br><br>3.1-33(a) | | | |
| F 0677<br>SS=D<br>Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>Based on observation, interview, and record review, the facility failed to ensure a dependent resident was offered a shave, oral care daily and hair washed during complete bed bath for 1 of 2 residents reviewed for ADLs (activities of daily living). (Resident 232)<br><br>Finding includes:<br><br>A record review was completed for Resident 232 on 12/7/2023 at 1:35 P.M. Diagnoses included, but were not limited to: metabolic encephalopathy, quadriplegia, chronic kidney disease, type 2 diabetes mellitus, and central cord syndrome at unspecified level of cervical spinal cord.<br><br>An Admission Minimum Data Set (MDS) assessment, dated 12/4/2023, indicated he was | F 0677 | **F677**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br><br>Resident 232 is offered and assisted by staff with shaving, oral care and shampooing hair during bed baths and as needed per preference.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective** | 01/19/2024 |

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| | dependent for all activities of daily living and had limited range of motion impairment to upper and lower extremities.<br><br>During an observation and interview on 12/6/2023 at 11:07 A.M., Resident 232's hair was greasy in appearance and he was unshaven. He indicated he had only been assisted with shaving one time, had only a few bed baths, went 6-7 days without his teeth brushed, and his hair not washed. He shaved at home every day and brushed his teeth 2-3 times a day.<br><br>During an observation and interview on 12/7/2023 at 1:15 P.M., his hair was greasy in appearance and he was shaved with patches missed. He indicated they still have not offered to wash his hair and they shaved him, but not very well.<br><br>During an observation and interview on 12/8/2023 at 1:46 P.M., his hair was greasy in appearance and he indicated he was not offered a shave or oral care today.<br><br>During an interview on 12/7/2023 at 2:56 P.M., CNA 2 indicated when she gave a bed bath, she would take in 2 wash basins, linens, and shower cap, then undressed and washed residents up and changed their linens.<br><br>During an interview on 12/8/2023 at 9:47 A.M., CNA 3 indicated, during morning care she washed residents' face, ears, neck, under arms and peri area, then put on deodorant, dressed them including putting on a brief or pull up, and brushed their hair.<br><br>During an interview on 12/8/2023 at 2:57 P.M., the Director of Nursing (DON) indicated when the staff did morning care for a dependent resident, | | **action(s) will be taken:**<br><br>All dependent residents have the potential to be affected by this finding. All dependent residents will be offered a shave, daily oral care and hair washed during bed bath/showers and as needed per preference.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br><br>Nursing staff in-serviced will be held on or before 1/19/24 on offering and assisting dependent residents with ADLS.<br>DNS/designee will review resident shower/bed bath sheets who are dependent with ADLS to ensure residents are getting shaved and their hair washed per their preference.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br><br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible | |

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| | she would expect them to give oral care, turn and reposition them if staying in bed, assist with meals, and all daily care. If they did a complete bed bath or shower, she expected them to gather all required supplies, introduce themselves, wash the residents, apply lotion, shave them, and clean the nails.<br><br>During an interview on 12/8/2023 at 3:07 P.M., CNA 2 indicated she gave Resident 232 a complete bed bath last evening, washed him up from top to bottom, applied lotion but forgot the shower cap so he did not get his hair washed.<br><br>During an interview on 12/11/2023 at 9:30 A.M., the DON indicated residents should be offered a shave every day.<br><br>A Care Plan, dated 11/27/2023, indicated "Resident requires assistance with ADLs including bed mobility, transfers, eating and toileting related to: metabolic encephalopathy, quadriplegia, Hx [history of] C4 [cervical disc] fx [fracture] s/p [status post] C3-C4 laminectomy, central cord syndrome, neurogenic bladder, cardiomyopathy, HTN [hypertension], CHF [congestive heart failure], severe protein calorie malnutrition, anemia, type 2 DM [diabetes], CKD [chronic kidney disease], Hx falling. Approach: assist with bathing as needed per resident preferences. Offer showers two times per week, partial bath in between. Assist with dressing/grooming/hygiene as needed. Encourage resident to do as much for self as possible. Assist with eating and drinking as needed x 1 assist. Requires dependent assist with eating. Natural teeth. Assist with oral care at least two times daily. Assist with bed mobility as needed, 2 person assist. Up ad lib in broda chair with hoyer lift x [of] 2 assist. Offer to toilet upon rising, | | for completing the QAPI Audit tool "Accommodation of Needs" weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. | |

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| | before or after meals, prior to bed and as needed throughout the night, 2 assist. Assist with toileting and/or incontinent care as needed. Resident prefers to not wear a brief and to lay on disposable chucks."<br><br>On 12/11/2023 at 9:29 A.M., the Administrator indicated he does not have a policy for ADL care and the staff follow the Skills Competency.<br><br>On 12/11/2023 at 9 A.M., the Administrator provided a skills competency titled, "Oral Care", dated 2/2010 and indicated the skills competency was the one currently used by the facility. The skills competency indicated "...1. Verify resident. 2. Provide privacy and explain procedure. 3. perform hand hygiene. 4. DON gloves. 5. Raise head of bed so resident is sitting up. 6. Drape towel under resident's chin. 7. Wet toothbrush and apply small amount of toothpaste. 8. First brush upper teeth and then lower teeth. 9. Hold emesis basin under resident's chin. 10. Have resident to rinse with water and spit into emesis basin. 11. Floss teeth, if applicable breaking off approximately 18 inches of floss. 12. Gently inset floss between teeth-start at one side of mouth continuing until all teeth on top and bottom are flossed between. 13. If requested give resident mouthwash. 14. Check teeth, mouth, tongue, and lips for odor, cracking, sores, bleeding, and discoloration. Check for loose teeth. 15. Remove towel and wipe resident's mouth. 16. Make sure resident is comfortable. 17. Doff gloves. 18. Perform hand hygiene. 19. Report any unusual findings to charge nurse. 20. Document procedure....<br>Skills competency titled, "Safety Razor", dated 2/2010 indicated: 1. Verify resident. 2. provide privacy and explain procedure. 3. Perform hand hygiene. 4. Raise head of bed so resident is sitting | | | |

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| | up if not in a chair. 5. Fill bath basin halfway up with warm water. 6. Drape towel under resident's chin. 7. DON gloves. 8. Moisten beard with washcloth and spread shaving cream on area. 9. Hold skin taut and shave beard in downward strokes on face and upward strokes on neck. 10. Rinse resident's face and neck with washcloth. 11. Pat dry with towel. 12. Apply after-shave lotion as requested. 13. Remove towel. 14. Doff gloves. 15. Perform hand hygiene. 16. Report any unusual findings to charge nurse. 17. Document procedure...."<br><br>3.1-38(a)(3)(B)<br>3.1-38(a)(3)(C)<br>3.1-38(a)(3)(D)(b)(1)<br>3.1-38(a)(3)(D)(b)(3) | | | |
| F 0679<br>SS=D<br>Bldg. 00 | 483.24(c)(1)<br>Activities Meet Interest/Needs Each Resident<br>§483.24(c) Activities.<br>§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.<br>Based on observation, record review, and interviews, the facility failed to ensure an individualized activity program was implemented for 2 of 2 residents reviewed for activities. (Residents 21 and 232)<br><br>Findings include: | F 0679 | **F679**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**: | 01/19/2024 |

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| | 1. The clinical record for Resident 21 was reviewed on 12/6/23 at 3:45 P.M. Resident 21 was admitted to the facility with diagnoses including, but not limited to: hemiplegia/hemiparesis following a cerebral infarction, encephalopathy, severe protein calorie malnutrition, dysphagia, aphasia, major depressive disorder, recurrent, anxiety disorder, chronic pain, gastrostomy, insomnia, adult failure to thrive, mistral valve insufficiency, emphysema and kidney stones.<br><br>On 12/6/2023 at 11:15 A.M., Resident 21 was observed lying in bed with the head of the bed slightly elevated. He indicated he "just lays there and does nothing." When asked what he liked to do before he entered the facility, he indicated he never liked to be around a lot of people, enjoyed fishing at the river and being outside. He never really watched a lot of television.<br><br>On 12/7/23 at 11:17 A.M., Resident 21 was observed lying in his bed awake. There was no television or radio noted in the his side of the room. The blind to the window was 2/3 of the way closed. Resident 21 said sometimes there were squirrels outside that ran along a fence near his window that he enjoyed watching. When asked if he had been out of bed, he indicated yesterday the therapist who was working on his motorized wheelchair had gotten him out of bed briefly.<br><br>On 12/8/2023 at 10:50 A.M., Resident 21 was observed lying in his bed awake. The resident had just received medications. The window blind was again 2/3 of the way closed. The resident again mentioned the squirrel that sometimes ran along the fence outside his window. He indicated the therapy department was adapting his power chair for him and he had not gotten out of bed recently, except with the therapy department. He | | Resident 21 is being offered individualized activities to meet the resident activity needs and per preference.<br>All activity staff have been educated on providing activities that support the physical, mental, and psychosocial well-being of all the residents, giving verbal reminders to residents regarding activities of interest, providing assistance as needed with activities, encouraging engagement/participation with activities, providing supplies for independent activity in room, assisting residents to activities as needed, and following the activity calendar. Activity director to audit activity care plans to ensure activity preferences are met.<br>Activity Director to review care assist activity documentation routinely to ensure documentation matches active and passive participation performed by the residents.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**:<br>All residents that reside in the facility have the potential to be affected by the deficient practice.<br>All activity staff have been educated on providing activities that support the physical, mental, and psychosocial well-being of all | |

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| | really enjoyed listening to country music, especially Conway Twitty. When asked if he had a radio in the room, he indicated at home he had a stereo, record player and DVD player, but it was at his daughter's house.<br><br>On 12/11/2023 at 10:20 A.M., Resident 21 was observed lying in his bed awake. He indicated he did not currently have a phone, radio, television or record player in his room. He was not sure where he could plug in the equipment if they were in his room. There were all types of clothing, personal hygiene care items and other medical care equipment noted to be covering the seat of a manual wheelchair, the top of a personal sized refrigerator, the window sill and the top of the three drawer dresser. There was only a Styrofoam cup with a straw on his overbed table. There were no books, puzzles, newspapers and/or magazines noted in his room.<br><br>The Annual MDS (Minimum Data Set) assessment, completed on 6/7/2023, indicated it was very important to him to listen to music he liked, very important to do his favorite activities and go outside. It was somewhat important to have books, newspapers, keep up with the news, and have pet visits.<br><br>The current care plan, last reviewed related to activities on 11/2/2023, indicated the following:<br>"Problem: Resident enjoys independent activity pursuits such as watching tv visits from his daughter...<br>Goal: Resident will participate in independent activities to their level of satisfaction and will be open to alternative programming...<br>Approach(s) Encourage daily socialization outside of room...<br>Encourage participation in scheduled | | the residents, giving verbal reminders to residents regarding activities of interest, providing assistance as needed with activities, encouraging engagement/participation with activities, providing supplies for independent activity in room, assisting residents to activities as needed, and following the activity calendar. Activity director to audit activity care plans to ensure activity preferences are met.<br><br>All residents have been interviewed by activity staff to ensure resident activities are offered per preferences as facility is able.<br><br>**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**:<br>All activity staff have been educated on or before 1/19/24 on providing activities that support the physical, mental, and psychosocial well-being of all the residents, giving verbal reminders to residents regarding activities of interest, providing assistance as needed with activities, encouraging engagement/participation with activities, providing supplies for independent activity in room, assisting residents to activities as needed, and following the activity | |

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| | programming... Offer items for room (Books, magazines, puzzles)"<br><br>The nursing progress note entries related to activities, completed by the Activity Director, on 11/01/2023 at 2:43 P.M., indicated the following: "resident prefers to do independent activities such as talking with others, visits from family, watching tv and relaxing."<br><br>A Nursing Progress Note related to activities, completed by the Activity Director on 8/2/2023 at 10:06 A.M., indicated, "resident prefers to do independent activities such as visits from family talking with others watching tv and relaxing. resident will be provided with activities supplies as needed."<br><br>A Nursing Progress Note, on 6/5/2023 at 12:30 P.M. indicated, "resident prefers to stay in bed. resident does go out with family and they come and visit. resident is on 1 to 1 programming. resident will be provided with activities supplies as needed."<br><br>During an interview with the Activity Director on 12/8/23 at 12:40 P.M., she agreed the resident spent most of his time in his room in bed, but did come out with his daughter at times. He was seen 1:1 by the activity assistants, but sometimes refused. When asked about music, she indicated he refused to come to music programs. She indicated he had been out of his room earlier this week on a motorized wheelchair with the therapy department. When asked about the puzzles, books and magazines, she indicated she was not sure what was provided to him or where it was located.<br><br>The 1:1 Activity Documentation, provided on | | calendar. Activity director to audit activity care plans to ensure activity preferences are met. Non-compliance with education to result in disciplinary action up to and including termination.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**:<br><br>Activities director/designee will complete the Social Enrichment Program QAPI tool weekly for 4 weeks, monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. | |

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| | 12/11/2023 by the Activity Director, indicated an Activity Assistant, Employee 11, had documented identical entries for Resident 21 for December 5 - 8. The entries indicated under the "Comments" section "Independently watch tv." The "Question or Task" section indicated the "yes" to participating and attending "Independently watch tv."<br><br>During an interview with the Activities Assistant, Employee 11, on 12/11/2023 at 10:10 A.M., she indicated the charting she had completed for Resident 21 was not 1:1 charting but just indicated he preferred independent activities in his room. When asked what type of independent activity Resident 21 enjoyed, she indicated he liked to watch TV. When asked again about watching TV and when the activity assistant was informed there was no television in Resident 21's room, she indicated it must have been removed but she was not sure how long ago the television was removed. When asked if she had completed any 1:1 activities for Resident 21 she indicated he had been added to the 1:1 activity schedule, "about a month ago" but the 1:1 activities were assigned to another activity staff person. She indicated he should be getting 1:1 activities 2 - 3 times per week. When asked if he was invited to group activities she indicated he was, but he normally declined, stating he was in too much pain to get out of bed. She indicated he also liked to go out with his daughter off the property to smoke, but she did not document those events in the record. When asked if she had provided any in room materials for the resident's independent activities, she indicated she had not, as he just preferred to watch TV. 2. A record review was completed for Resident 232 on 12/7/2023 at 1:35 P.M. Diagnoses included, but were not limited to: metabolic encephalopathy, quadriplegia, chronic kidney | | | |

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| | disease, type 2 diabetes mellitus, and central cord syndrome at unspecified level of the cervical spinal cord. The resident was admitted on 11/27/2023 and tested positive for COVID on 11/29/2023.<br><br>During an interview on 12/6/2023 at 11:11 A.M., Resident 232 indicated he had not been approached by staff regarding what type of activities he enjoyed. He only has a TV to watch in his room.<br><br>During an interview on 12/8/2023 at 10:35 A.M., Resident 232 indicated no one had offered him any activities to do. He enjoyed reading the newspaper, magazines and listening to music.<br><br>During an interview on 12/8/2023 at 12:50 P.M., the Activity Director indicated she visited a new admission when she did her 7- day assessment. If a resident was in isolation, she would do one on one's (1:1) daily and asked if there were any activities they would like to do. She had not brought Resident 232 anything to do and she did not do his assessments until 12/6/2023.<br><br>During an interview on, 12/12/2023 at 9:49 A.M., the Activity Aid 11 indicated she did not do one on one's with him, it would be documented under the sub-category.<br><br>The Activity Assessment, dated 12/6/2023 at 12:14 P.M., indicated it was very important to listen to music he likes and somewhat important to have books, newspaper, and magazines to read while in the facility.<br><br>A Care Plan, dated 12/6/2023, indicated "Resident enjoys independent activity pursuits such as watching tv, visits from brother, talking with | | | |

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| | others and relaxing. Short Term Goal: Resident will participate in independent activities to their level of satisfaction and will be open to alternative programming. Approach: Encourage daily socialization outside of room, Encourage participation in scheduled programming. Offer items for room (Books, magazines, puzzles)."<br><br>On 12/12/2023 at 1:53 P.M., the Regional Nurse Consultant provided a policy titled, "Activities", dated 1/2006, and indicated the policy was the one currently used by the facility. The policy indicated, "...It is the policy of this facility to provide for an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident in accordance with the comprehensive assessment...."<br><br>3.1-33(a)<br>3.1-33(b)(8) | | | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>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.<br>Based on interview and record review, the facility failed to follow physician's orders related to administration of insulin for 1 of 2 residents reviewed for insulin use. (Resident 53)<br><br>Finding includes: | F 0684 | **F684**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient** | 01/19/2024 |

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| | During an interview with Resident 53 on 12/6/2023 at 9:59 A.M., he indicated he received insulin injections on a daily basis.<br><br>A record review was completed on 12/7/2023 at 9:17 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2 and major depressive disorder.<br><br>A Quarterly Minimum Data Set (MDS) assessment indicated Resident 53 received insulin.<br><br>Physician's Orders on the current POS (Physician's Order Summary) included the following:<br>- Lispro 100 units/milliliter, give 15 units subcutaneously three times a day, and hold for a blood sugar reading of less than 110, dated 3/6/2023.<br>- Lantus Solostar 100 unit/milliliter, give 25 units at bedtime, and hold for a blood sugar reading less than 110, dated 3/7/2023.<br>- Accucheck (glucometer device to monitor blood sugar levels) as needed for signs and symptoms of hypo/hyperglycemia and notify the medical doctor if the blood sugar is than 60 or greater than 350 as needed, dated 3/7/2023.<br><br>The Medication Administration Record (MAR) for December 2023 indicated blood sugar readings on 12/4/2023 at 5:00 P.M. (recorded late at 7:41 P.M.) and 12/6/2023 at 5:00 P.M. (recorded late at 6:02 P.M.) of "low".<br><br>Additional blood sugar recordings reviewed indicated the following:<br>10/12/2023 7:52 pm 91<br>10/21/2023 4:30 pm 99<br>10/29/2023 3:59 pm 78 | | **practice:**<br><br>The physician was notified of Resident #53 blood sugars below 110 for 10.12.23, 10.21.23, 10.29.23, 10.31.23, 11.2.23, 11.10.23, 11.13. No additional action was needed.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**<br><br>All diabetic residents have the potential to be affected by this finding. A facility audit will be completed by DNS/designee for all residents who receive insulin. Any identified residents where physician orders were not followed will be assessed for hyper/hypoglycemia and the MD will be notified.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br><br>The DNS/designee will in-service all nurses on or before 1/19/24 pertaining to following MD orders on parameters and insulin administration. DNS/designee will review “Vitals out of Range” which includes blood sugars daily in AM clinical to ensure parameters and | |

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| | 10/31/2023 1:57 pm 64<br>11/2/2023 3:36 pm 82<br>11/10/2023 4:21 pm 101<br>11/13/2023 4:13 pm 99<br><br>A Care Plan, initiated on 2/22/2023, indicated Resident 53 was at risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus. The interventions included to document abnormal findings and notify the medical doctor.<br><br>During an interview on 12/12/2023 at 10:00 A.M., the Director of Nursing indicated a glucometer reading of "low" meant the blood sugar reading was below 60. She indicated the nurse should be following the orders provided by the physician, and the insulin should have been held if a blood sugar was below 110.<br><br>On 12/12/2023 at 1:18 P.M., the policy "MatrixCare Physician Orders Policy" was provided. The policy indicated, " ...All new orders will be entered into MatrixCare Physician Orders by the nurse receiving the order ...."<br><br>3.1-37(a) | | MD notification was completed. Any identified will be addressed with MD for follow up.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br><br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Diabetic Monitoring” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up | |
| F 0757<br>SS=D<br>Bldg. 00 | 483.45(d)(1)-(6)<br>Drug Regimen is Free from Unnecessary Drugs<br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or | | | |

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|---|---|---|---|
| | 155695 | A. BUILDING 00<br>B. WING | 12/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| RIVERSIDE VILLAGE | 1400 W FRANKLIN ST<br>ELKHART, IN 46516 |

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| | §483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>Based on observation, record review and interviews, the facility failed to ensure the medication regimen for 1 of 5 residents reviewed for medications was free from unnecessary medications related to the lack of laboratory levels. (Resident 22)<br><br>Finding includes:<br><br>The clinical record for Resident 22 was reviewed, on 12/8/2023 at 2:28 P.M., with diagnosis, including but not limited to: hyperlipidemia and hypothyroidism<br><br>The current Physician's Orders for medications for Resident 22 included the following: Levothyroxine (a medication to address thyroid issues) and Lipitor (a medication to address elevated cholesterol levels). The most recent laboratory blood levels for a TSH (thyroid stimulating hormone) and Lipid panel (blood test to address various cholesterol levels in the body) were completed in 2021, over two years ago.<br><br>During an interview with the DON (Director of | F 0757 | **F757**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>Resident #22 no longer resides at the facility.<br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**<br><br>All residents have the potential to be affected by this finding. A facility audit will be completed by DNS/designee of all medications that relate to routine laboratory levels. Any residents identified without laboratory levels related to a medication that requires routine monitoring will be communicated to the MD for follow up. | 01/19/2024 |

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| | Nursing), on 12/11/2023 at 11:17 A.M., she indicated the physician only ordered labs when he felt they were pertinent or when something was going on with the resident. She did not think there was a policy for monitoring medication levels.<br><br>During an interview with the DON, on 12/12/2023 at 1:38 P.M., she confirmed the facility did not have a policy regarding monitoring of medication levels via laboratory testing.<br><br>An excerpt from the "GP Notebook, primary care notebook.com - ear-nose-and - throat, Dec 21, 2019", regarding the professional standard of monitoring medication levels for the use of Levothyroxine indicated the following: "...Response to thyroxine (levothyroxine sodium) is best monitored biochemically. Thyroid function should be assessed every 6-8 weeks until the patient is euthyroid and then rechecked annually, aiming to maintain T4 and TSH within the normal range."<br><br>An excerpt from the National Institutes of Health, NCB Bookshelf, dated December 4, 2023, included the following recommendation in respect to monitoring blood for lipitor use: "...Patients starting atorvastatin should have liver function tests and a lipid panel performed at baseline, with a repeat lipid panel after six weeks of therapy. Liver function tests should be repeated as clinically indicated. Once the patient is stable, lipids can be checked every 6 to 12 months..."<br><br>3.1-48(a)(3) | | **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>The DNS/designee will in-service all nurses on or before 1/19/24 pertaining to medications related laboratory levels. DNS/designee will review new medication orders daily in AM clinical. Identified medication that require routine monitoring will be verified that the lab order is present, MD will be notified of any concerns identified.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The DNS/designee will be responsible for completing the QAPI Audit tool “Lab Monitoring” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. | |
| F 9999<br><br>Bldg. 00 | | | | |

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| | State Rules<br><br>3.1-14 PERSONNEL<br><br>(q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following:<br>(7) Documentation of orientation to the facility and to the specific job skill.<br><br>This rule was not met as evidenced by:<br><br>Based on record review and interview, the facility failed to ensure 2 of 5 employee files reviewed contained documentation of job specific orientation. (Employees 8 & 9)<br><br>Finding includes:<br><br>A review of the employee records was completed on 12/6/2023 at 2:14 P.M.<br><br>The review indicated that LPN 8 and CNA 9 did not have job specific orientation completed.<br><br>During an interview with the Payroll Coordinator on 12/12/2023 at 8:47 A.M., she indicated that those employees did not have job specific orientation completed. These orientations should be completed.<br><br>On 12/12/2023 at 12:21 P.M., the administrator indicated there was not a policy available related to job specific orientation. | F 9999 | **F9999**<br><br>**What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br><br>No residents were affected by this practice. The new Payroll and Benefits Coordinator will be educated in Onboarding and Orientation policies and procedure. Employees 8 and 9 have specific job orientation in their file<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**<br><br>All residents have the potential to be affected.<br>New employee files were audited for accuracy and completion and to ensure specific job orientation is in the employee file.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br><br>New employee files were audited for accuracy and completion by 1/19/24 to ensure specific job | 01/19/2024 |

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| | | | orientation is in the employee file.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br><br>Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). The Payroll and benefits Coordinator/designee will be responsible for completing the QAPI Audit tool “Employee Records” weekly for 4 weeks, monthly for 6 months and quarterly thereafter for at least 2 quarters. If the threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up | |