STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155455	A. BUILDING 00 B. WING	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESLEYAN HEALTH CARE CENTER	729 WEST 35TH ST MARION, IN 46953

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00448390. This visit included a State Residential Licensure Survey. Complaint IN00448390 - Federal/State deficiencies related to the allegations are cited at F790. Survey dates: December 11, 12, 13, 16, and 17, 2024 Facility number: 000557 Provider number: 155455 AIM number:100291240 Census Bed Type: SNF/NF: 98 Residential: 7 Total: 105 Census Payor Type: Medicare: 6 Medicaid: 55 Other: 37 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 30, 2024.	F 0000	This plan of correction is the center's credible allegation of compliance. 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.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences Based on observation and interview, the facility failed to ensure a resident's call light was within reach for 1 of 3 residents reviewed for	F 0558	Resident #39 has had his call light clipped to his sheet and during random observation is noted to be	01/09/2025

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

Debra Smith | RN DCS | 01/06/2025

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	environment. (Resident 39) Findings include: During a random observation, on 12/11/24 at 10:50 a.m., Resident 39 was propelled in a high-backed wheelchair to his room by a staff member. The resident was left facing his television. His call light was not in reach. During an interview, on 12/11/24 at 11:55 a.m., Resident 39 indicated his call light was not within his reach. He was waiting for someone to place him in his bed so he could lay down. He had been waiting for over an hour for assistance. During a random observation, on 12/11/24 at 2:50 p.m., Resident 39 was lying in bed. The call light was sitting on top of his roommate's nightstand, located between his bed and his roommates' bed, not within his reach. During an interview, on 12/11/24 at 2:50 p.m., the resident indicated he was unsure where his call light was located. During an interview, on 12/11/24 at 2:54 p.m., LPN 11 went down to the resident's room to look for his call light. She indicated it was sitting on top of his roommate's nightstand located between their beds and not within his reach. She thought staff forgot to put it back within his reach when they replaced his bedsheets earlier in the day. Resident 39's clinical record was reviewed on 12/13/24 at 9:29 a.m. Diagnoses included flaccid hemiplegia affecting his left nondominant side, vascular dementia, unspecified severity, with other behavioral disturbance, nontraumatic intracerebral hemorrhage, unspecified, and unspecified tremor.		removing call light and moving it. Care plan has been updated. Resident experienced no negative findings as a result of this alleged deficient practice. Residents that reside in the facility have the potential to be affected by the alleged deficient practice. Education to staff has been completed on placing call lights within resident reach when in their rooms. An audit tool will be used during daily rounds on random residents and locations daily X 8 weeks then 3X weekly for 8 weeks, and weekly thereafter until substantial compliance is achieved as defined by QA. QA Committee will review compliance for a minimum of 6 months. Noncompliance will result in re-education and progressive discipline as indicated.	

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	A quarterly Minimum Data Set (MDS) assessment, dated 9/5/24, indicated he was cognitively intact. His upper extremity had impairment on one side and his lower extremities had impairment on both sides. He was dependent on oral hygiene, toileting, shower/bathing, lower body dressing and rolling to the left and right. He required substantial/ maximal assistance for upper body dressing and personal hygiene. A care plan, dated 9/11/19 and revised on 9/9/24, indicated the resident was at risk for falls related to his history of falls, left sided hemiplegia, use of total mechanical lift, use of anti-depressants and anti-anxiety medications. Interventions included having his call light within reach while in his room. During an interview, on 12/17/24 at 2:54 p.m., the DON indicated call lights were to be within the reach of residents. A current policy, titled "Call Lights: Accessibility and Timely Response", provided by the Corporate Nurse, on 12/16/24 at 3:52 p.m., indicated the following: " ...1. All staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. 5. Staff will ensure the call light is within reach of resident and secured, as needed ...." 3.1-3(v)(1)			
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment Based on observation, record review, and interview, the facility failed to maintain a homelike environment by failing to repair a damaged wall for 1 of 3 residents reviewed for environment.	F 0584	Resident # 103 has had the area noted in her room repaired. Resident experienced no negative findings as a result of this	01/09/2025

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	(Resident 103) Findings include: Resident 103's clinical record was reviewed on 12/13/24 at 10:09 a.m. Diagnoses included multiple sclerosis, atherosclerosis, peripheral vascular disease, and major depressive disorder. An annual Minimum Data Set (MDS) assessment, dated 9/7/24, indicated the resident was cognitively intact and independent with eating, oral hygiene, and bed mobility. She required minimal assistance with toileting hygiene, showering, and personal hygiene. During an observation of Resident 103's room on 12/11/24 at 11:47 a.m., something blue could be seen at the bottom left corner of the heating/cooling unit. During an interview with Resident at the same time, she indicated the blue glove(s) had been pushed into the hole by an x-ray technician who was performing an x-ray on her. She could not provide a date, but indicated the technician felt cold air coming through the hole and plugged it up. The original unit had caulking around it which sealed the unit from the outside air. However, the unit had been replaced and no caulking had been applied around the new unit. The unit was on a north-facing wall and a lot of cold air came through on cold days. She had asked, one more than one occasion, for the hole to be repaired. She could not remember the dates of the requests. She had asked "TLC management" to repair the hole. During an interview with the administrator on 12/13/24 at 12:14 p.m., she indicated there had been no work orders submitted to fix the hole in the residents wall. She did not know anything		alleged deficient practice. Residents that reside in the facility have the potential to be affected by the alleged deficient practice. Education has been completed on notification to maintenance on reporting areas requiring repair in facility and how to complete a work order for maintenance. An audit of resident rooms has been completed to determine if there are areas requiring repair. An Audit tool will be used to audit 4 resident rooms per hall weekly X8 weeks, then 3 resident rooms per hall weekly X 8 weeks, then 10 random resident rooms ongoing for a minimum of 6 months or until substantial compliance as defined by QA. QA committee will review compliance for minimum of 6 months. Non-compliance will result in re-education and progressive discipline as indicated.	

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	about a hole. She went to the resident's room to observe the hole in the wall. The blue glove(s) used to plug the hole would not have come from the facility because they did not use blue glove(s) in the facility. During an interview with the administrator on 12/17/24 at 8:48 a.m., she indicated there was no work order to indicate the heating/cooling had been replaced, but it had, indeed, been replaced. During an interview with the maintenance director on 12/17/24 at 9:08 a.m., he indicated the unit must have been replaced before 6/2/24 because the resident's room received a "deep clean" on 6/2/24. He provided a picture, dated 6/2/24, of the heating/cooling unit in Resident 103's room. The lower left corner of the unit was not visible, but he was able to identify it as a new unit based on the type of plug visible in the picture. During an interview with the administrator on 12/17/24 at 2:03, she indicated it was impossible a hole in a wall would have been ignored. She put much effort into keeping the facility in good condition and there was no way she would have left a hole in the wall. She rounded the facility often and would have seen the hole. It was obvious from the surrounding environment that great effort was put into making the facility look nice and filling in a hole was an "easy fix". At that time, a hole in the wall of the Director of Nursing's office was noted on the wall behind the DON's desk. During an interview with the corporate nurse on 12/17/24 at 2:05 p.m., she indicated the facility had a massive guardian angel program, the wound nurse saw the resident regularly for wound dressing changes, and other nurses			

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	provided daily care as well. Someone would have seen the hole. During an interview with the administrator on 12/17/24 at 2:08 p.m., she indicated the facility did not have a policy pertaining to maintenance or upkeep of the physical property or resident's rooms.			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review, and interview, the facility failed to provide daily grooming assistance for 1 of 3 residents reviewed for activities of daily living (ADLs). (Resident 112) Findings include: During an observation, on 12/11/24 at 11:03 a.m., Resident 112 sat in a chair in the dining/activity area and participated in a kick ball type activity. He was not shaved. During an observation, on 12/12/24 at 8:13 a.m., Resident 112 sat at the dining table feeding himself breakfast. He was not shaved. During an observation, on 12/16/24 at 8:14 a.m., Resident 112 sat at the dining table feeding himself breakfast. He was not shaved. During an observation, on 12/16/24 at 10:08 a.m., Resident 112 sat in a chair in the dining/activity area participating in exercises. He was not shaved. His facial hair length was the length of the thickness of two quarters stacked upon each other. Resident 112's clinical record was reviewed on	F 0677	Resident #112 has been shaved. Resident care plan reviewed and updated as resident does refuse to allow staff to shave him at times. Resident experienced no negative findings as a result of this alleged deficient practice. Residents that have hair growth on their face have the potential to be affected by the alleged deficient practice. Rounds were completed and care plans reviewed and updated for those residents desiring to maintain hair growth on their face or refuse to allow staff to assist them with shaving. Education has been completed with staff on 1/8/2024 on the grooming tasks including shaving residents daily and informing DCS or designee when resident will not allow staff to assist them with shaving or when resident wants to maintain hair growth on their face. Rounds will be completed using	01/09/2025

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	12/13/24 at 8:08 a.m. Diagnoses included Alzheimer's disease, unspecified and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Physician's orders included quetiapine fumarate (antipsychotic) 25 milligrams (mg) - give 12.5 mg by mouth at bedtime for 14 days - started 12/11/24. A 10/24/24 quarterly Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. He required supervision/touching assistance with personal hygiene. He received restorative therapy in range of motion and dressing and grooming seven days of the seven-day assessment period. A care plan initiated on 9/24/24 and last reviewed on 11/3/24 indicated the resident needed assistance with his ADLs related to a change in his mobility and his cognitive status. The clinical record lacked resident refusals for ADL care/assistance or behaviors in the past 14 days. During an interview, on 12/16/24 at 10:36 a.m., CNA 16 indicated both men and women were shaved at least one time a week. Resident 112 required the staff to shave him. He did have some beard growth. She shaved him with showers, and he was due for a shower tomorrow. During an interview, on 12/16/24 at 10:42 a.m., CNA 17 indicated men and women residents were generally shaved on shower days and not between times. During an interview, on 12/16/24 at 11:01 a.m.,		an audit tool to ensure residents that do not want hair growth on their face are being shaved daily X 8 weeks, then 3X weekly X8 weeks, then weekly until substantial compliance is achieved as defined by QA Committee. QA Committee will review compliance for a minimum of 6 months. Care plans will be updated as indicated. Non-compliance will result in re-education and progressive discipline as indicated.	

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	CNA 18 indicated shaving of the men and women residents was performed on shower days. For men residents she shaved them at least every other day if it was needed. During an interview, on 12/16/24 at 3:34 p.m., the Director of Nursing (DON) indicated the staff should attempt to shave male residents daily. She was unable to locate documentation of Resident 112's refusals or behaviors with ADL care/assistance. A facility policy, dated 6/2013 and last revised 6/2021, provided by the Nurse Consultant, titled "Personal Hygiene" indicated the following: " ...Personal hygiene will be performed 2 times daily in the morning and before bed ...Personal hygiene may include, but is not limited to: ...Shaving ...." 3.1-38(a)(3)(D)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview and record review, the facility failed to ensure services for bed mobility were provided with two staff members present to a dependent resident who required total assistance of two staff for bed mobility for 1 of 3 residents reviewed for falls. (Resident 99) This deficient practice resulted in Resident 99 falling from the bed and sustaining a fracture left knee joint. Findings include: Resident 99's clinical record was reviewed on 12/13/14 at 11:29 a.m. Diagnoses included, but were not limited to, quadriplegia (a severe medical condition characterized by the partial or total loss of function in all four limbs and the torso), left	F 0689	Resident #99 has had new fall intervention put in place with her agreement. Residents that reside in facility have the potential to be affected by the alleged deficient practice. Care plans have been reviewed and updated. Education has been completed for staff on accessing the care plans and Kardex for the status and staff assistance needed for bed mobility on 1/8/2024. Education has been completed for staff updating care plans on 1/8/2024.	01/09/2025

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	elbow contracture, left shoulder contracture, left wrist contracture, left hand contracture, right shoulder contracture, right wrist contracture, right hand contracture, major depressive disorder, bipolar disorder, restless leg syndrome, and generalized anxiety disorder. A current care plan, dated 3/1/24, revised on 5/28/24, and reviewed on 12/2/24, indicated Resident 99 required assistance with activities of daily living (ADLs) related to quadriplegia. Interventions included a total assist of two staff members with bed mobility. She required a total assist of 1-2 staff when toileting and required a total assist of one to two staff members with bathing. A quarterly Minimum Data Set (MDS) assessment, dated 8/20/24, indicated she had upper and lower extremity impairment on both sides. She was dependent on toileting hygiene, shower/bathing, upper and lower body dressing, eating, and rolling to the left and right in bed. She was cognitively intact. The resident did not have any falls since the prior assessment. A Significant Change MDS assessment, dated 11/18/24, indicated she had upper and lower extremity impairment on both sides. She was dependent on toileting hygiene, shower/bathing, upper and lower body dressing, eating, and rolling to the left and right in bed. She was cognitively intact. An MDS progress note, dated 11/18/24 at 3:40 p.m., indicated Resident 99 had complaints of frequent neck pain and overall generalized discomfort in the past five days. The worst pain was a five on a 0-10 pain scale. The resident received routine and as needed pain medications		Care plans have been reviewed and updated for residents requiring assistance for bed mobility to ensure the correct staff assistance is on the Kardex and in care plan. Fall rounds will be completed on random residents and locations to ensure fall interventions in place daily X 8 weeks, then 5 times weeks X8 weeks, then 3 times weekly until substantial compliance is obtained as defined by QA committee. QA committee will review compliance for a minimum of 6 months. Care plans will continue to be reviewed at least quarterly thereafter. Non-compliance will result in re-education and progressive discipline as indicated.	

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	which she stated was effective. The resident voiced occasional shortness of breath with exertion and at rest. The resident was non-ambulatory and used a mechanical lift for transfers. The resident was totally incontinent of bowel and bladder and utilized incontinence products and moisture barrier cream. A nursing progress note, dated 11/29/24 at 8:30 p.m., indicated the CNA reported assisting Resident 99 in her bed without assistance. He rolled her to the left side of the bed to adjust the bed sheets and incontinence pad, when the residents right leg went over the side of the bed. The resident stated she went onto the floor and hit her head. The resident ended up developing a skin tear to her sacrum that was 2 centimeters (cm) long by 0.2 cm width with no depth. Range of motion was normal per resident's current physical condition. Neurological checks were initiated, within defined limits, and she was alert and oriented times four. Four staff members assisted in getting the resident off the floor and back into her bed. There were no progress notes documented between 11/29/24 at 8:30 p.m., when the fall occurred, and 11/30/24 at 6:36 a.m., when the resident had complaints of pain. A nursing progress note, dated 11/30/24 at 6:36 a.m., indicated the CNA notified the nurse that the resident was experiencing 10/10 pain following her fall the previous night. Her left leg and back caused the majority of her pain. Upon assessment, the resident's left leg was extremely swollen and painful to touch. The nurse spoke with both the resident and family who indicated they wanted her sent to the Emergency Room (ER) for evaluation			

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	A nursing progress note, dated 11/30/24 at 7:08 a.m., indicated the resident's representative arrived at the facility and Emergency Medical Services (EMS) was contacted for transport. A hospital imaging service report, dated 11/30/24 at 10:03 a.m., indicated findings of a depressed medical tibial plateau fracture. A nursing progress note, dated 11/30/24 at 12:37 p.m., indicated the resident returned from the Emergency Room with a diagnosis of medial tibial plateau (concave part of the tibial plateau, which is the flat top of the tibia bone in the knee) fracture and a urinary tract infection (UTI). A nursing progress note, dated 12/2/24 at 1:11 p.m., indicated the resident requested for her bed to be put back the way it was prior to her fall, so she could see out the window and watch her television. The DON was notified. An Interdisciplinary Team (IDT) note, dated 12/2/24 at 1:52 p.m., indicated the root cause of her fall was that the resident's leg rolled over further than the staff member expected. Since the resident had no control over her body, the momentum pulled her to the floor. Other contributing factors included quadriplegia, other cord compression, chronic pain syndrome, muscle spasms, spinal stenosis, chronic obstructive pulmonary disease, major depression, anxiety, sick sinus syndrome, critical illness myopathy, and contractures. Interventions in place prior to fall included her call light and personal items were within reach and to remind the resident to change position slowly. New education included proper ADL care of the resident and resident requested to have her bed moved up against the wall to make her feel safer. The fall care plan had been reviewed and updated.			

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Current physician orders, on 12/13/24, included amitriptyline (antidepressant) 25 milligram (mg) daily, aripiprazole (atypical antipsychotic) 10 mg daily, Eliquis (anticoagulant) 5 mg daily, gabapentin (anticonvulsant) 200 mg twice daily, and oxycodone-acetaminophen (narcotic) 7.5-325 mg every six hours.

A current care plan, dated 9/6/24 and revised on 12/2/24, indicated the resident was at risk for falls related to immobility, use of narcotics, use of psychotropics, and pain. An intervention, dated 9/6/24, indicated the resident would have her personal items within reach. An intervention, dated 9/6/24, indicated her call light would be within reach. An intervention, dated 9/6/24, indicated she needed to be reminded to change her position slowly. A post fall intervention, dated 12/1/24, indicated she would have her bed against the wall as it made her feel safe. The resident had chosen to move her bed away from the wall in order for her to look out of her window, dated 12/1/24. A post fall intervention, dated 12/2/24, indicated the resident was to wear proper footwear or non-slip footwear when she was up.

A current care plan, initiated 11/30/24 and revised on 12/6/24, indicated the resident had a traumatic fracture to her left depressed medical tibial plateau due to fall. An intervention, dated 11/30/24, indicated the implementation of her pain care plan.

A current care plan, initiated 3/1/24 and revised on 12/6/24, indicated the resident has chronic pain syndrome, osteoarthritis right knee, and osteoporosis. She was at risk for acute pain related to surgical site left lower quadrant abdominal and left umbilicus, muscle spasm, Chronic Obstructive Pulmonary Disease (COPD),

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	spinal stenosis, constipation, and urinary retention, irritable bowel syndrome, gastroesophageal reflux disease (GERD), depression and left depressed medical tibial plateau fracture on 11/30/24. Interventions, dated 3/1/24, indicated her pain medication would be administered as ordered, observe for increased sedation, constipation, and respiratory depression, staff would observe to determine if she was experiencing non-verbal signs of pain, and when she was experiencing pain to check for decrease external stimulation as much as possible. A current care plan, initiated 3/6/24 and revised on 7/3/24, indicated the resident was totally incontinent and not a candidate for a bowel program due to irritable bowel syndrome. Interventions included applying barrier cream as indicated, receive medications as ordered, check for incontinence every two hours, and more frequently as needed and assist the resident with incontinence care. During a random observation, on 12/11/24 at 10:54 a.m., Resident 99 was lying in bed on her back, covered with a sheet. A small travel pillow was around her neck for support. The bed was located away from the wall. During a random observation, on 12/11/24 at 2:36 p.m., Resident 99 was lying on her back in bed with her eyes closed, covered with a sheet. A small travel pillow was around her neck for support. The bed was located away from the wall. During a random observation, on 12/12/24 at 10:49 a.m., Resident 99 was lying on her back in bed, covered with a sheet. The bed was located away from the wall.			

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	During a random observation, on 12/12/24 at 2:17 p.m., Resident 99 was lying on her back in bed with her eyes closed. The bed was elevated and a touch call pad was within reach. A small travel pillow was around her neck for support. The bed was located away from the wall. During an interview, on 12/13/24 at 2:08 p.m., Resident 99 indicated, on 11/29/24, that CNA 4 had changed her bed sheets and incontinence pad. The resident advised CNA 4 that he needed to have a second staff member help with changing her incontinence pad and bedding. CNA 4 assured her that he could do it by himself. CNA 4 rolled her back and forth a few times. She was lying on her left side at the edge of the bed, her right leg went forward off the bed, causing her to roll off the bed. She hit her head and upper back on the chair beside her bed. During an interview, on 12/13/24 at 2:30 p.m., Resident 99 indicated, on 11/29/24, she had been lying flat in bed during incontinence care. Her bed was away from the wall. She was on her left side, on the edge of the bed. She felt like both of her legs ended up sliding off the bed, which caused the rest of her body to fall off the bed. It happened so fast she didn't have time to say anything to the staff member before falling off the bed. Her upper bed rails were up, and she flipped over the top bedrail. She hit the back of her head and the top part of her back on the chair at her bedside. She had back pain after the fall occurred. The following morning, she was sent out to the hospital where she was diagnosed with a left knee fracture. She saw the orthopedic physician today, and he would see her back in 4 weeks for a follow-up appointment. When provided care, she usually scrunched up in a ball, as she was contracted in her extremities. Being rolled around			

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	in bed caused her to be in pain. During an interview, on 12/13/24 at 2:40 p.m., LPN 3 indicated facility staff knew to use two people when assisting the resident with care. However, if they were familiar with her, one person could provide care for her. Everyone who worked for this facility used two people for her care. During an interview, on 12/13/24 at 3:33 p.m., CNA 4 indicated, on 11/29/24, he had assisted Resident 99 when she needed cleaned up and her bedding changed. CNA 4 had rolled the resident onto her left side, which was on the opposite side of the bed from the CNA. When he rolled Resident 99 over to change her brief, her right leg went over the side of the bed where he was standing. He had his hand on her side, near her waist, and was able to keep her from fully falling off the bed. He was able to run around the bed, get behind the resident, and lowered her to the ground. He didn't feel like the resident's knees touched the floor. He was able to get right up behind her and lowered her to the ground. He was unsure how she hurt her knee. He was told by other staff members that it was easy to provide incontinence care to the resident, but just to be careful as she was contracted. The resident was not scrunched up or contracted while he was providing care. The nurse was right outside her door when the fall occurred. Resident 99 was not hollering or calling out. He denied the resident hit her head or back on anything. The nurse assisted him with lowering the resident to the floor. He indicated he did not have access to the facility's computer system. During an interview, on 12/13/14 at 4:04 p.m., RN 5 indicated, on 11/29/24, she was outside the resident's door when the fall occurred. She heard the resident scream. When she entered the room,			

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	Resident 99 was already on the floor. The resident was a two-person physical assist during care. CNA 4 was from another facility, and they had informed him that the resident was a two-person physical assist before providing care. RN 5 didn't feel CNA 4 could have lowered the resident to the floor by himself. RN 5 felt the resident slid out of the bed. The resident preferred to have her bed elevated. RN 5 did not see any swelling or redness to the resident's knee during the assessment after her fall. Later that next morning, the resident was sent out to the ER for complaints of knee pain. She was diagnosed with a fracture of her left knee. A point of care task, retrieved on 12/13/24 at 4:25 p.m., indicated staff members documented Resident 99 required one person assist with bed mobility 10 out of 11 days prior to her fall from 11/18/24 to 11/29/24, and 10 out of 14 days after her medial tibial plateau fracture, from 12/1/24 to 12/13/24. During an interview, on 12/16/24 at 8:40 a.m., CNA 6 indicated Resident 99 was a two-person physical assist for bed mobility and incontinence care due to her contractures. During an interview, on 12/16/24 at 8:41 a.m., CNA 7 indicated Resident 99 was a two-person physical assist with care. One person could do it on their own, but CNA 7 wouldn't recommend it due to the resident being a quadriplegic and contracted. During an interview, on 12/16/24 at 9:53 a.m., the DON indicated, on 11/29/24, she interviewed Resident 99 and CNA 4 once the resident returned from the hospital. The resident indicated that CNA 4 was trying to turn Resident 99 over in bed and that the resident was close to the edge of the bed. CNA 4 had his hand on Resident 99's waist.			

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	CNA 4 indicated Resident 99's knees went off the bed and the momentum pulled Resident 99 to the ground. CNA 4 tried to stop the resident from falling. The DON talked to the resident regarding an intervention of moving her bed against the wall so she would feel safe during care. Resident 99 was agreeable, but later wanted her bed moved back to where it was originally located. The DON provided education to all staff members that Resident 99 was a two-person physical assist with bed mobility. CNA 4 had access to the facility computer system. She verified that the resident was a two-person assist for bed mobility, and it did show that information on the care plan. During an interview, on 12/16/24 at 1:30 p.m., the Corporate Nurse provided documentation of CNA 4 accessing the clinical record from November 11, 2024 through December 5, 2024. During an interview, on 12/17/24 at 10:23 a.m., the DON indicated that CNA 4 was toileting (incontinence care) Resident 99 at the time of her fall. Her care plan indicated she was a 1-2 staff member assistance for toileting (incontinence care) and bathing. She was unsure why she was marked as a two-person assist for bed mobility. She was in the process of changing the resident's care plan to two-person assist for toileting (incontinence care) and bathing. During an interview, on 12/17/24 at 10:37 a.m., CNA 9 indicated Resident 99 was a two person assist with bed mobility. Bed mobility included rolling from left to right and providing During an interview, on 12/17/24 at 10:49 a.m., the DON indicated all staff members have been educated that Resident 99 was a two person assist for incontinence care and that Resident 99 was			

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	agreeable with using bolsters while in bed. During an interview, on 12/17/24 at 10:58 a.m., Resident 99 indicated she was incontinent and used a brief. When staff toileted her, they changed her brief and bed pad. During an interview, on 12/17/24 at 11:00 a.m., LPN 10 indicated Resident 99 was incontinent and unable to use the bedpan due to quadriplegia with contractures. The resident did not have any feeling from her upper chest down to her toes. She could move her arms enough to hit her call light, but she was unable to grasp or pull. During an interview, on 12/17/24 at 11:24 a.m., CNA 9 indicated Resident 99 was fully paralyzed and unable to tell when she needed to use the restroom. They used a disposable bed pad for her. She was unable to wear briefs due to her contractures. When they were providing toileting care, they were rolling her to either side of the bed. A current policy, titled "Fall Investigation and Risk Evaluation", provided by the Corporate Nurse, on 12/16/24 at 3:52 p.m., indicated the following: " ...It is the policy of the facility to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assisted devices to prevent avoidable accidents ...." 3.1-45(a)			
F 0790 SS=D Bldg. 00	483.55(a)(1)-(5) Routine/Emergency Dental Srvcs in SNFs Based on observation, interview, and record review, the facility failed to arrange dental	F 0790	No resident was identified due to the nature of the survey.	01/09/2025

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	appointments for a resident who misplaced or lost their dentures for 1 of 1 resident reviewed for dental services. (Resident B) Findings include: During observations on 12/11/24 at 3:39 p.m., 12/12/24 at 2:48 p.m., and 12/13/24 at 2:40 p.m., the resident's top denture was visible when she smiled, but the lower denture plate was not present. During an interview with Resident B's representative, on 12/12/24 at 9:34 a.m., they indicated Resident B was admitted in February of 2023. At that time, the resident had a full set of dentures (top and bottom plates). Within approximately 3 months, the bottom plate went missing. The facility recommended Company A, which they used for dentures. An appointment was made for Resident B. After a significant delay,which the facility could explain, the bottom plate never arrived. By September of 2023, the resident still did not have a lower denture. The family canceled the insurance with Company A and decided to take the resident to Company C to get the denture replaced. Within 3 weeks, the resident had the new lower denture. In December of 2023, the lower plate went missing again. Five months later, in May of 2024, a social services representative indicated the facility would arrange an appointment to have the denture replaced. Twelve months later, in December of 2024, the resident still had no lower plate denture. The representative indicated the facility had left it to the family to get a replacement. Social services was supposed to be working on it, but nothing had transpired to date. Resident B's clinical record was reviewed on		Residents that reside in facility and have the need for dental services have the potential to be affected by the alleged deficient practice. Resident records review for dental services consents and last date of service has been completed. Dental assessments have been completed on residents to determine any current need for dental services. Education completed on dental services and notification of need for residents for dental services on 1/8/2024. Dental assessments completed on residents in facility. Dental services scheduled to be provided for residents as indicated. Review of any residents with oral/dental complaints or needs will be discussed daily Monday through Friday in Clinical Meeting. An audit tool will be used to ensure services are provided and indicated. Dental evaluations will be completed quarterly and as needed. QA Committee will review compliance for a minimum of 6 months. Social Services will schedule dental services as indicated. Non-compliance will result in re-education and progressive discipline as indicated.	

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	12/13/24 at 3:41 p.m. Diagnoses included, but were not limited to, hypertension, heart failure, unspecified dementia, chronic obstructive pulmonary disease, and depression. Review of the resident's personal inventory, dated 3/2/23, indicated the resident had both upper and lower dentures. A Minimum Data Set (MDS) annual assessment, dated 11/6/24, indicated the resident had a diagnosis of dementia and was severely cognitively impaired. Resident B's care plan lacked indication of the use of dentures. A progress note, dated 4/5/23, indicated the dentist from Company A had made a house-call for the initial placement of both the upper and lower dentures. A dental note, dated 5/13/23, indicated the resident was informed by a dentist from Company A that she had a minimal lower ridge and might need to use adhesive on her lower dentures for a proper fit. Upper and lower impressions were taken and shipped to the lab. A dental note, dated 8/14/23, indicated no upper or lower removable appliances were present upon examination by the dentist from Company A. The resident was edentulous (without teeth). The resident wanted a new set of dentures. She was a good candidate for dentures because she previously had worn dentures. A reprint was sent in that day to make a new upper and lower denture set. The reprint was necessary because the previous set of dentures, made by Company A, had been lost in the mail.			

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	The clinical record lacked documentation to indicate the replacement dentures were received by the facility or provided to Resident B. A social service note, dated 9/15/23 at 10:15, indicated the resident had felt like crying on 9/12/23 but had been easily redirected when she heard her dentures would be delivered soon. During an interview with the Social Services Director, on 12/16/24 at 10:26 a.m., she indicated the resident had twice misplaced her lower set of dentures. The resident often removed them. She still had her upper dentures. The SSD did not know how long Resident B had been without the lower denture, but it was a simple fix to get it replaced. The SSD had spoken to Resident B's representative in recent months but had no documentation of any conversations with him, nor from the resident's record regarding dentures. During an interview with LPN 20 on 12/16/24 at 11:51 a.m., she indicated Resident B had not had her lower denture for awhile, but did not know for how long. She could not find documentation about the resident's dentures in the clinical record. During an interview with the Administrator on 12/17/24 at 8:50 a.m., she indicated she did not understand why new dentures would be purchased because the resident took out the lower plate and refused to wear it. She did not know if the repeated removal of the lower plate was because it did not fit properly. The facility would not continue to replace a denture for someone who refused to wear it. During an interview with the SSD, on 12/17/24 at 4:31 p.m., she provided a document from Company			

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	A. The document, dated 8/14/23, indicated the dentures had been lost in the mail. There was a hand-written note on the document that indicated the resident's representative refused to accept a spare set of dentures. The SSD indicated the administrator had written the note. There was no statement from the company to indicate the spouse had refused to accept the dentures. A "Cancellation of (Company A) Insurance" document, dated 10/7/23, was provided by the DSS on 12/17/24 at 4:31 p.m. The document indicated the insurance policy for Resident B had been canceled, with an effective date of 9/30/23. A current facility policy, dated 3/5/24 and titled "Dental Services," provided by the Corporate Nurse Consultant on 12/16/24 at 3:52 p.m., indicated the following: "...It is the policy of this facility to assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care. Definitions: Routine dental services - means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments. Policy Explanation and Compliance Guidelines - 1) The dental needs of each resident are identified through the physical assessment and MDS assessment processes, and are addressed in each resident's plan of care... b) Oral care and denture care shall be provided in accordance with identified needs and as specified in the plan of care. Staff shall be mindful of resident dentures when providing care and alert to situations where dentures may be displaced, such as common with residents with dementia or those known to remove dentures at will and place them in areas other than the denture cup. c) Referrals to...dental provider shall be made as			

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	appropriate...5) The facility will not be responsible for lost or broken dentures unless it is determined that it was the fault of the facility. a) A blanket policy of facility non-responsibility for the loss or damage of dentures is prohibited. b) The facility shall determine responsibility for the loss or damage of dentures on a case-by-case basis, considering the circumstances surrounding the loss/damage, resident characteristics, and the resident's plan of care. 6) For residents with lost or damaged dentures, the facility will refer the resident for dental services within three days...d) The resident and/or resident representative shall be kept informed of all arrangements...8) For residents or resident representatives who do not wish to be referred for dental services...c) The resident's plan of care will be revised to reflect preferences. 9) All actions and information regarding dental services, including any delays related to obtaining dental services, will be documented in the resident's medical record...." This citation relates to Complaint IN00448390. 3.1-24(a)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure infection prevention and control strategies for transmission-based precautions were followed for 2 of 2 residents reviewed for COVID-19 isolation precautions. (Resident 35 and 67) Findings include: 1. During a random observation, on 12/16/24 at 8:22 a.m., Resident 35's door was closed with an	F 0880	Resident #35 or no other residents were affected by the alleged deficient practice. Staff was re-educated on proper donning of Personal Protective Equipment. Resident experienced no negative findings as a result of this alleged deficient practice. Residents in facility and under	01/09/2025

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	over-the-door organizer containing gown, gloves, and N95 masks hanging on the door. The organizer lacked face shields, and the door lacked a sign indicating what precautions were required. During a random continuous observation, on 12/16/24 at 12:11, RN 12 applied a gown, gloves, and an N95 mask and entered Resident 35's room. She wore regular glasses. The door lacked a sign indicating what precautions were required, and the organizer did not contain face shields. During an interview, upon leaving Resident 35's room, RN 12 indicated the resident was on isolation for COVID-19 though there was no sign on the door. She had not applied a face shield because she wore glasses and had been told if glasses were worn, no face shield was required. During a random observation, on 12/16/24 at 1:25 p.m., Resident 35's door was closed. The door lacked a sign indicating what precautions were required. The over-the-door organizer lacked face shields. During a random observation, on 12/16/24 at 3:45 p.m., Resident 35's door was closed. The door lacked a sign indicating what precautions were required. The over-the door organizer lacked face shields. Resident 35's record was reviewed on 12/16/24 at 10:02 a.m. A physician's order for the resident to be in strict single isolation due to positive COVID test every shift for 10 days was started on 12/15/24. A care plan initiated on 12/15/24, with a revision on 12/16/24, indicated the resident required strict single room isolation related to COVID-19.		precautions for infection control have the potential to be affected by the alleged deficient practice. Education has been provided to staff on the correct donning and doffing of PPE and the infection control precautions and isolation policy on 1/8/2024. Infection control rounds will be completed daily X8 weeks, then 5 times a week X8 weeks then weekly thereafter for a minimum of total 6 months. QA Committee will follow for a minimum of 6 months or until substantial compliance has been achieved as defined by QA Committee. Non-compliance will receive re-education and progressive discipline as indicated,	

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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
	During an interview, on 12/16/24 at 3:47 p.m., QMA 13 indicated Resident 35 was in isolation for COVID-19. The door typically would have a sign indicating what personal protective equipment (PPE) was required. For COVID-19 isolation, she wore a gown, N95 mask, gloves, and a face shield to enter the room. During an interview, on 12/16/24 at 3:51 p.m., RN 5 indicated when a resident was on COVID-19 isolation, a gown, N95 mask, gloves and a face shield were required to enter the room. She wore a face shield with her glasses. During an interview, on 12/16/24 at 3:57 the Infection Preventionist (IP) Nurse indicated a sign indicating the precautions required would typically be on a resident's door in isolation. Face shields were required with glasses unless the glasses were goggles to enter a COVID-19 isolation room. 2. During a continuous random observation, on 12/16/24 at 12:15 p.m., CNA 15 placed an N95 mask over her surgical mask, applied gloves and gown, and then entered Resident 67's room to deliver a meal tray. LPN 3 spoke briefly to CNA 15 before she entered the room. On Resident 67's door was a sign that indicated the resident required contact and droplet isolation. During an interview, after leaving the room, CNA 15 indicated she normally put the N95 mask on first. She had done it backwards and knew the N95 mask should not go over the surgical mask. LPN 3 had told her the N95 mask should not be placed over the surgical mask. CNA 15 wanted to make sure meals were delivered in a timely manner. Resident 67's clinical record was reviewed on 12/16/24 at 1:34 p.m. A physician's order for the			

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	155455	A. BUILDING 00 B. WING	12/17/2024

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	resident to be in strict single isolation due to positive COVID test every shift for 10 days was started on 12/13/24. A care plan initiated on 12/13/24 indicated the resident required strict single room isolation related to COVID-19. During an interview, on 12/16/24 at 3:57 p.m., the IP nurse indicated the N95 mask should not have been placed over the surgical mask when CNA 15 entered a COVID-19 isolation room. "Infection Control Guidance: SARS-CoV-2" (June 2024) was retrieved on 12/19/24 from the Centers for Disease Control and Prevention (CDC) website on 12/19/24. The guidance included the following " ...HCP [health care providers] who enter the room of a patient with suspected or confirmed SAR-CoV-2 infection should adhere to Standard Precautions and use a NIOSH [National Institute for Occupational Safety and Health] Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) ...." "How to Use Your N95 Respirator" (May 2023) was retrieved on 12/19/24 from the National Institute for Occupational Safety and Health website. The guidance included the following " ... N95 respirators must form a seal to the face to work properly ...." A facility policy, implemented 11/1/23 and revised on 5/29/24, provided by the Nurse Consultant on 12/16/24 at 3:52 p.m., titled "COVID-19 Prevention, Response and Reporting," indicated the following: "HCP who enter the room of a resident with suspected or confirmed SARS-CoV-2			

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	infection should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection ...." 3.1-18(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaint IN00448390. Complaint IN00448390 - Federal/State deficiencies related to the allegations are cited at F790. Survey dates: December 11, 12, 13, 16, and 17, 2024 Facility number: 000557 Residential Census: 7 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed December 30, 2024.	R 0000	This plan of correction is the center's credible allegation of compliance. 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.	
R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance Based on observation, record review, and interview, the facility failed to have the most recent State Survey results readily available to the public. This deficiency had the potential to affect 7 of 7 residents residing in the facility. Finding includes:	R 0042	No resident was identified as being affected by the alleged deficient practice. The survey was printed and placed in the binder making it available to the residents. Residents residing in the Assisted	01/09/2025

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	During an observation, on 12/16/24 at 8:28 a.m., a binder in the front lounge labeled survey results rested on a bottom shelf of the table near the facility entrance. The binder was reviewed and contained the skilled nursing portion of the facility survey results. The binder lacked the facility's assisted living most recent annual survey results, completed on 12/4/23. During an interview, on 12/17/24 at 8:28 a.m., the Director of Nursing (DON) indicated she printed off the survey results for both the skilled and assisted living portions of the facility. The facility had the one binder containing the survey results near the entrance. The facility did not provide the survey results for either skilled or assisted living in another location of the facility. She reviewed the binder's contents and was unable to locate the assisted living's most recent annual survey results. During an interview, on 12/17/24 at 3:50 p.m., the DON indicated the facility did not have a policy on the posting of the survey results and used the state regulations.		Living have the potential to be affected by the alleged deficient practice. Survey binder will be checked monthly and after each survey by HFA/designee for a minimum of 6 months. QA Committee will follow compliance for a minimum of 6 months.	