STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 00 B. WING	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00410442 and Complaint IN00409997. This visit included a State Residential Licensure Survey. Complaint IN00410422- No deficiencies related to the allegations are cited. Complaint IN00409997- No deficiencies related to the allegations are cited. Survey dates: July 18, 19,20,21,24 and 25, 2023 Facility number: 013005 Provider number: 155816 AIM number: 201256400 Census Bed Type: SNF/NF: 32 SNF: 13 Residential: 11 Total: 56 Census Payor Type: Medicare: 12 Medicaid: 30 Other: 3 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 3, 2023	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Recertification and State Licensure Survey and Investigation of Complaint IN00410442 and Complaint IN00409997 conducted July 18, 2023 through July 25, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of August 17, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified			

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

Janet Worley 08/17/2023

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	existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record	F 0550	F 550 Resident Rights/Exercise of	08/17/2023

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	review, the facility failed to ensure residents were treated with respect and dignity for 2 of 2 residents reviewed for abuse, 2 of 4 residents reviewed for dignity, 1 of 3 residents reviewed for ADLs (activities of daily living,) and 6 of 7 residents that attended in resident council. (Resident 's 1, 5, 8, 14, 21, 29, 19, 31, and 38) Findings include: 1. The clinical record for Resident 21 was reviewed on 7/18/23 at 10:45 a.m. The resident's diagnosis included, but was not limited to, stroke with hemiplegia affecting left side. The Quarterly MDS (Minimum Data Set), completed on 6/17/23, indicated Resident 21 was moderately cognitively impaired. The resident needs extensive assistance of one staff person with dressing. The clinical record for Resident 29 was reviewed on 7/20/23 at 11:45 a.m. The resident's diagnosis included, but was not limited to, heart failure. The Quarterly MDS (Minimum Data Set), completed on 6/27/23, indicated Resident 29 was cognitively intact. An interview was conducted with Resident 21 on 7/18/23 at 11:10 a.m. She indicated Certified Resident Care Assistant (CRCA) 5 was rough during care. She does not place my bra on correctly, and it hurts. This has been reported recently, but it still continues to go on. The CRCA she had today was gentle with the bra placement, but CRCA 5 was not when she does it. She did not want to receive care by CRCA 5. An observation and interview was conducted		Rights – 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? -Resident 5 and resident 38 have discharged -Residents 1, 8, 14, 21, 29, 19, and 31 have no further concerns identified. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. -All residents have the potential to be affected by the alleged deficient practice. ED/DHS/SSD/ designee will educate staff on the Resident Rights/Dignity policy and conduct sensitivity training with the nursing staff. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? - As a measure of ongoing compliance, the SSD/designee will complete 5 random resident interviews weekly x8 weeks, then every other week x8 weeks and then monthly x2 months ensure staff are following the Resident Rights /Dignity service standard.	

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	with Resident 21 and Family Member (FM) 7 on 7/21/23 at 9:41 a.m. Resident 21 indicated her bras were too small. At that time, the resident had lifted up her shirt, and an observation was made of the resident's bra. The sports bra the resident was currently wearing did not appear to be too small. The resident indicated CRCA 5 was rough putting on her bra causing pain to her affected arm. FM 7 indicated after the last reported incident about rough care with bra placement by CRCA 5, FM 7 had purchased larger sports bras for the resident instead of buying bras that snap in the front or back. FM 7 did not believe CRCA 5 was abusive she thought the larger bras would address the problem. The plan as of now, CRCA 5 will not provide care any longer to Resident 21. An interview was conducted with CRCA 5 via phone on 7/21/23 at 2:41 p.m. She indicated FM 7 sits out the clothes Resident 21 was to wear every day. The clothes that was sat out for the resident was what CRCA 5 placed on the resident. Since the previous incident with care concerns, she had not provided care to the resident until last week. CRCA 5 had received education and training on assistance with dressing a resident that has hemiplegia prior to providing care to the resident last week. During care, the resident had not voiced any concerns with care that she received by her. An interview was conducted with Resident 29 on 7/24/23 at 9:48 a.m. She indicated she was Resident 21's roommate. She has overheard verbal interactions between the staff and Resident 21. She was unable to identify which staff members, but the staff were not nice to Resident 21. They are disrespectful. Resident 21 can be "loud" and "obnoxious" at times, but she was not cognitively intact. The resident will turn on her call light and		4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. 5. Date of completion: 08/17/23	

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	ask for something from the staff. The staff will then tell her roommate "no" and "just be quiet." The staff will then leave the room and never return to provide her roommate what she has requested. That happens all the time. The staff appear to be agitated with Resident 21 during interactions and not trained how to address a resident in her condition. She did not believe the staff were abusive, but disrespectful. The investigation of the reportable incident was provided by the Executive Director on 7/26/23 at 10:36 p.m. The investigation indicated a teachable moment was provided to the CRCA 5. It indicated ..."What's Expected: CRCA [5] should explain to the resident what care they are there to perform to providing ADL care. When a resident reports pain/discomfort during ADL care, CRCA should stop, ensure safety, and notify the nurse prior to continuing care. CRCA should being by dressing the affected/impaired side first to promote the highest level of functioning and comfort during ADL care." 2. The clinical record for Resident 49 was reviewed on 7/18/23 at 11:00 a.m. The resident's diagnosis included, but was not limited to, heart failure. The Admissions MDS (Minimum Data Set), completed on 6/17/23, indicated Resident 49 was moderately cognitively impaired. The resident needs extensive assistance of one staff person with toileting. An interview was conducted with Resident 49 on 7/18/23 at 10:49 a.m. She indicated a couple of weeks ago, she had received care by a male CRCA she did not know his name, but was "very rude" and rough during toileting care. She indicated the CRCA while assisting her with toileting made			

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	statements to her, "you need to do this stuff yourself. Staff don't have time for this." The CRCA then wiped her with a paper towel instead of toilet paper. She has not had the CRCA since. She indicated it was not CRCA 22 nor CRCA 23, because they are pleasant. An interview was conducted with the Executive Director and the Assistant Director of Nursing Services (ADNS) on 7/18/23 at 11:26 a.m. The ADNS indicated she was unsure who the male CRCA was that provided care to Resident 49. The only male CRCAs the facility has was CRCA 22 and CRCA 23. An interview was conducted with Nurse Consultant 1 on 7/24/23 at 4:00 p.m. The facility has made the assumption it was a former male employee that had provided care to Resident 49. 3. The clinical record for Resident 5 was reviewed on 7/19/23 at 9:45 a.m. Her diagnoses included, but were not limited to: acute kidney failure, polyneuropathy, chronic obstructive pulmonary disease, morbid obesity, hyperlipidemia, atrial flutter, depression, spinal stenoises, hypertension, lymphedema, and degenerative joint disease. The 7/7/23 functional impairment care plan for Resident 5 indicated she required extensive/total assistance with transfers, bed mobility, and toileting, keeping in mind that ADL ability could fluctuate frequently. The 7/4/23 Admission MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status) score of 14, indicating she was cognitively intact. An observation and interview was conducted			

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	with Resident 5 on 7/19/23 at 9:51 a.m. She was lying in bed. Her legs were very dry and chafing, but had a moisturizing treatment applied to them. She indicated one day last week, she pressed her call light because she needed to use the bedpan. She was "soaking wet," because she didn't feel it coming out. When the CNA (Certified Nursing Assistant) came to the room, she asked her to change her brief and informed her she needed to use the commode to have a bowel movement. The CNA left the room and said they would be back, but by the time the CNA returned, she had a bowel movement in the bed. The CNA was "mad at me and snatched on my leg." Resident 5 informed her it hurt, but then she "she snatched" on the other leg. When the CNA was putting the brief on, Resident 5 informed her it hurt when she wiped her, but the CNA "didn't pay any attention to me. I was crying, in tears." Resident 5 informed the CNA of her age and that she didn't appreciate being treated like this. Resident 5 could not recall the CNA's name, but gave a physical description of her. Resident 5 indicated she didn't think the CNA had enough training, "like she didn't know any better, but when I told her it hurt, it still hurt, not empathizing with the patient at all." Resident 5 informed the nurse on duty at the time of what happened, who was the same nurse working the unit now. An interview was conducted with LPN 11 on 7/19/23 at 10:06 a.m. She indicated she remembered the incident Resident 5 was referencing and she informed LPN 6 of it. Resident 5 asked LPN 11 if she could help her out, because she didn't feel clean, like there was some paper stuck to her after getting her brief changed. Resident 11 wasn't crying at the time, but she "looked serious, saying she needed some help." LPN 11 assisted Resident 5 and "she did have a			

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piece of tissue stuck on her." LPN 11 got a wash cloth, "washed her up real good,' and let LPN 6 know that Resident 5 felt like the CNA was "rough with her." LPN 11 didn't know who the CNA was. Resident 5 informed LPN 11 that she thought the CNA scratched her with her nails. LPN 11 changed Resident 5's brief 2 more times that day, looked for scratches, but she didn't find any scratches on her.

An interview was conducted with LPN 6 on 7/19/23 at 10:10 a.m. She indicated she remembered the incident. The CNA involved was CNA 5, who was currently suspended.

A telephone interview was conducted with CNA 5 on 7/21/23 at 2:42 p.m. She indicated she'd worked at the facility for 7 years. She'd cared for Resident 5 only one time, and it was in bed. She change her brief. Resident 5 "responded pretty good." Resident 5 cried sometimes, but CNA 5 was unsure why she was crying. CNA 5 asked Resident 5 why she was crying and Resident 5 responded by requesting her to just shut her door. Resident 5 did not say anything to CNA 5 about her fingernails that day.
CNA 5 indicated she had a "layover" on her fingernails that were about an inch past the tip of her finger. CNA 5 never found out why Resident 5 was crying, and no one ever discussed her care of Resident 5 with her until this interview.

4. The clinical record for Resident 38 was reviewed on 7/18/23 at 2:00 p.m. Her diagnoses included, but were not limited to, polyneuropathy.

The 6/2/23 admission assessment indicated to provide assistance as needed for bed mobility, eating, toileting, and transfers.

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	The 6/6/23 Admission MDS (Minimum Data Set) assessment indicated she required extensive assistance of 2 staff for bed mobility and transfers and was totally dependent on one staff person for toileting. She had a BIMS (brief interview for mental status) score of 14, indicating she was cognitively intact. An interview was conducted with Resident 38 on 7/18/23 at 2:08 p.m. She indicated the staff at the facility did not treat her with dignity and respect. The previous night, around 1:00 a.m., she had to go to the restroom, so she pressed her call light. The CNA came into her room and told her that she didn't need to push her call light every time she needed to get up, and that she could get out of bed on her own. Resident 38 did not recall the CNA's name, but gave a physical description of her. On 7/24/23 at 4:00 p.m., NC (Nurse Consultant) 1 provided the name and phone number of the CNA who worked Resident 38's unit the night shift of 7/17/23 into 7/18/23. It was CNA 5. A telephone interview was conducted with CNA 5 on 7/25/23 at 9:40 a.m. She indicated she did not provide care for Resident 38 on the night shift of 7/17/23, nor did she work that unit. 5. The clinical record for Resident 1 was reviewed on 7/19/23 at 10:20 a.m. Her diagnoses included, but were not limited to, hypertension. The 4/9/23 Quarterly MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status) score of 15, indicating she was cognitively intact. An interview was conducted with Resident 1 on			

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	7/19/23 at 10:23 a.m. She indicated the past couple of mornings, the CNA had been rough with her, but she couldn't remember her name. The CNA wouldn't answer her questions. "She's been terribly frustrated." The CNA was "rushing with me. It hurt." It took a while for Resident 1's body to "loosen up. She knew it was hurting me." The CNA raised her voice and "I don't do well with that. It's more the tone and way she talks to me. I'm not stupid. She's forceful that way...She is my favorite, just rough and rude lately." 6. The clinical record for Resident 14 was reviewed on7/19/23 at 11:03 a.m. The Resident's diagnosis included, but were not limited to, diabetes and anemia. A Quarterly MDS Assessment, completed 5/13/23, indicated she was cognitively intact. 7. The clinical record for Resident 31 was reviewed on 7/19/23 at 10:45 a.m. The resident's diagnosis included, but was not limited to, end stage renal disease. The Quarterly MDS (Minimum Data Set), completed on 6/18/23, indicated Resident 31 was cognitively intact. On 7/24/23 at 11:36 a.m., Resident 14 and Resident 31 were interviewed. Resident 14 indicated the staff are frequently on their phones while in the dining room. The residents in the dining room have to wait until the staff are done on their phones to have drinks served to them. The staff share information about residents of the building while in the dining room. Resident 31 indicated that the Dietary Manager has been rude to her when she has asked for substitutes during meals. 8. A resident council meeting was conducted on			

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	7/18/23 at 2:31 p.m., with the attendance of Resident's 1, 5, 8, 14, 29, 19, and 31. The council indicated the CRCA staff were rude and disrespectful. They lack training in providing care to someone that has disabilities and diseases. An interview was conducted with the Director of Nursing Services on 7/25/23 at 3:30 p.m. She indicated the staff have been educated on care needs, resident rights and abuse. The Resident Rights Guidelines policy was provided by NC (Nurse Consultant) 1 on 7/25/23 at 8:44 a.m. It read, "Our residents have aright to...a. Be treated with dignity and respect...f. Be treated fairly, courteously and with respect by all staff." 3.1-3(a) 3.1-3(t)			
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.			

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	§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing			

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	written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the			

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	155816	A. BUILDING 00 B. WING	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	grievance decision. Based on observation, interview and record review, the facility failed to initiate a grievance for a resident, to address grievances, to follow up on a resident's grievance, and to ensure their grievance policy included all necessary components for 2 of 4 residents reviewed for abuse and 1 resident reviewed for choices. (Resident 20, 31, and 38) Findings include: 1. The clinical record for Resident 20 was reviewed on 7/19/23 at 9:24 a.m. The Resident's diagnosis included, but were not limited to, end stage renal disease and diabetes. A Quarterly Minimum Data Set Assessment, completed 5/10/23, indicated he was cognitively intact. He could make his needs and wants known and understand what was being said to him, and that he received dialysis. During an interview on 7/19/23 at 9:57 a.m., Resident 20 indicated he was very upset because the facility owed him money and was not giving it back to him. He had attempted to pay his bill and had been informed by the business office that he had a credit to his bill of about $7,000.00. He had asked for a refund but had not received it. During an interview on 7/20/23 at 11:38 a.m., the BOM (Business Office Manager) indicated that Resident 20 did have a credit to his billing account. She had reached out to the corporate office about the credit. During an interview on 7/21/23 at 1:06 p.m., Resident 20 indicated he had attempted to pay his bill 4 months ago and was told that he did not owe	F 0585	F 585 Grievances – 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? • Resident 20 grievance resolved without concern. • Resident 31 grievance resolved with no further concerns identified at this time. • Resident 38 has discharged from facility. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. • All like Residents have the potential to be affected by the alleged deficient practice. ED or designee to educate nursing staff on the “Resident Concern and Grievance Policy”. Resident concern forms as well as contact information for the grievance officer are accessible in a common area for anonymous reporting. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? • As a measure of ongoing compliance ED or designee will audit resident grievances to ensure timely follow up and resolution. Audits to include 5	08/17/2023

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	anything, he had a credit to his account. He had spoken with the Business Office Manager about his bill about a month ago and was told he had a credit of around $7,000.00. He asked about a refund and the Business Office Manager had told him that since she was new and was not sure how to go about getting a refund for him, she would contact the corporate office. He had also asked the current SSD (Social Service Director) about his money and was told he would have to talk with the business office. During an interview on 7/21/23 at 3:14 p.m., the SSD indicated that Resident 20 had spoken to him about an outstanding credit to his bill about 2 weeks ago. He had not created a grievance about the concern. The SSD had encouraged Resident 20 to take up the issue with the business office. 2. The clinical record for Resident 31 was reviewed on 7/19/23 at 10:45 a.m. The resident's diagnosis included, but was not limited to, end stage renal disease. The Quarterly MDS (Minimum Data Set), completed on 6/18/23, indicated Resident 31 was cognitively intact. An interview was conducted with Resident 31 on 7/19/23 at 9:04 a.m. She indicated the staff do not make her bed in the morning and she has repeatedly asked for it to be done. She goes to dialysis on Mondays, Wednesdays and Fridays and was gone from 4:30 a.m. to 10:30 a.m., on those days. The staff make her roommate's bed every morning, but do not make hers. She knows it might be a "petty" request, but she has asked housekeeping and nursing staff who was responsible for it and why can't her bed be made. The staff will not address her concern with bed making. This has been going on for a couple of		resident grievances 5 times a week times 4 weeks, then every 2 weeks times 2 months, then monthly times 3 months and until continued compliance is maintained. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. 5. Date of completion: 8/17/23	

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	months. The June and July 2023 grievances report provided by Nurse Consultant 1 on 7/21/23 at 10:43 a.m., did not include concerns with bed making for Resident 31. Observations were made of Resident 31's room on 7/21/23 at 9:29 a.m., 7/21/23 at 11:35 a.m., and 7/24/23 at 10:26 a.m. Resident 31 was not present in her room. The resident's bed was not made, but her roommate's bed was. An interview was conducted with Housekeeper 4 on 7/24/23 at 10:28 a.m. She indicated Resident 31 had discussed with her about the bed making and who was responsible for making the beds. She had told her housekeeping does not make the residents' beds. Housekeeper 4 had not told anyone about the discussion she had with Resident 31, because she had overheard the resident speaking with another staff member about it. An interview was conducted with Certified Resident Care Assistant (CRCA) 3 on 7/24/23 at 10:51 a.m. She indicated she was the CRCA for Resident 31 that day. She had not made the resident's bed that morning. She does not like to make the resident's bed while she was present in her room. She makes the resident's bed after lunch while the resident sits in the front lobby. 3. The clinical record for Resident 38 was reviewed on 7/18/23 at 2:00 p.m. Her diagnoses included, but were not limited to, intellectual disability and epilepsy. The 6/6/23 Admission MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status) score of 14, indicating			

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	she was cognitively intact. An interview was conducted with Resident 38 on 7/18/23 at 2:14 p.m. She indicated another resident, Resident 1, called her an ***hole on 7/16/23 in the dining room. This made her feel upset. Resident 38 didn't tell anyone that day, because she was too upset about it, but informed CNA (Certified Nursing Assistant) 15 the next day, on 7/17/23. CNA 15 responded by telling Resident 38 not to pay any attention to Resident 1. There was no information in the clinical record to indicate follow up on Resident 38's verbal grievance. An interview was conducted with the ED (Executive Director) on 7/18/23 at 2:45 p.m., at which time, Resident 38's verbal grievance was discussed. He indicated this was the first he'd heard of it, and would have staff look further into it. On 7/21/23 at 1:05 p.m., the ED provided a list of all resident grievances from May, 2023 to present. There was no grievance for Resident 38. An interview was conducted with the ED on 7/20/23 at 3:46 p.m. He indicated he signed off on all grievances in the facility and he had no grievances for Resident 38. CNA 15 should have reported it to their supervisor on 7/17/23, when Resident 38 told her about it. The SSD (Social Services Director) looked into it after it was reported to the ED on 7/18/23. The 7/20/23 social services note, written by the SSD, read, "...followed up with resident about a curse word being said to her by another resident. Per staff who interviewed resident on 7/18/23.			

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	Resident was ok & not concerned about what was said to her. When writer spoke to her today. Resident said she felt scared & threaten [sic] at that moment. At this time she does not have those feelings." An interview was conducted with the SSD on 7/21/23 at 2:05 p.m. He indicated he was unaware of the situation until 7/18/23. He indicated he would have liked to have known if Resident 38 was emotionally disturbed by the incident. She had an intellectual disability, so that was a concern. The facility needed to address it, because it could have progressed. Resident 38 may have wanted to react. When he followed up with Resident 38 on 7/20/23, he told her to sit with other residents in the dining room who are more courteous and respectful. He was going to make sure he had a presence in the dining room to calm things down. CNA 15 should have informed the ED of Resident 38's allegation. He was not surprised Resident 1 would say something like this to Resident 38, but he'd never heard Resident 1 curse at anyone before. An interview was conducted with the ED on 7/21/23 at 11:04 a.m. He indicated when a resident verbally indicated a grievance, the process was for the resident to inform staff, so staff could enter the grievance electronically. He was unsure if a resident could fill out a grievance by themselves. An interview was conducted with the SSD on 7/21/23 at 11:15 a.m. He indicated the process for a CNA to complete a grievance for a resident was for the CNA to put it on notebook paper and leave it in the mailbox of any staff member who had access to fill out an electronic grievance, such as himself, the ED, DON, or one of the nurses. A resident had to file a grievance with staff, but			

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	there was no way for a resident to file a grievance anonymously. An observations of the front desk was made with the SSD on 7/21/23 at 11:16 a.m. The Guest Relations staff member, who sat at the front desk, provided a copy of a resident grievance form that she found in the top right desk drawer of the reception desk. There was no sign of availability on the desk, and the drawer was inaccessible to residents or visitors. The Resident Concern Process policy was provided by the ED on 7/21/23 at 12:00 p.m. It read, "Purpose To provide a process for handling, tracking and resolving customer concerns to provide excellence in customer service. Procedures...3. The facility staff will follow the Resident Concern Process flow chart when any concern or complaint is voiced....5. Enter the concern using the desktop icon labeled 'Resident Concern Form.' All concerns should be entered electronically....6. Concerns are reviewed in morning meeting, noting new entries and assigning them for follow up and resolution...11. The Social Services Director will monitor for follow through and resolution with Executive Director support." The policy did not reference notifying a resident of their right to file a grievance; how to file a grievance anonymously; preventing further potential violations of any resident right; or maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. An interview was conducted with the SSD on 7/21 at 2:16 p.m. He reviewed the Resident Concern Process policy and indicated he did not see where it referenced notifying a resident of their right to			

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	file a grievance; how to file a grievance anonymously; preventing further potential violations of any resident right; or maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. 3.1-7(a)(2) 3.1-7(b)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure MDS (Minimum Data Set) assessment accuracy for 2 of 2 residents reviewed for resident assessment. (Residents 14 and 46) Findings include: 1. The clinical record for Resident 46 was reviewed on 7/20/23 at 11:08 a.m. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease. He was admitted to the facility on 6/5/23. The 6/11/23 Admission MDS assessment indicated he received one insulin injection in the last seven days. The physician's orders indicated he was not ordered insulin since admission, and the June and July, 2023 medication administration records indicated he did not receive any insulin injections since his admission. An interview was conducted with Resident 46 on 7/18/23 at 11:00 a.m. He indicated he was not	F 0641	F641: Accuracy of Assessment 1. Residents 46 and 14 were affected. Residents are without adverse effects. 6/11/23 MDS for Resident 46 modified to change N0350 insulin injections to “0”. 1/4/23 MDS for Resident 14 modified to change A1500 Preadmission Screening and Resident Review (PASRR) to “Yes”. 2. All residents have the potential to be affected. MDS Coordinator educated on accurately coding N0350 insulin injections and A1500 Preadmission Screening and Resident Review (PASRR) per RAI guidelines. 3. As a measure of ongoing compliance, the Assessment Support Nurse or designee will conduct an audit of five residents (as available) for correct coding of	08/17/2023

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	diabetic and not receiving insulin in the facility. An interview was conducted with the MDSC (Minimum Data Set Coordinator) on 7/20/23 at 11:36 a.m. She reviewed Resident 46's 6/11/23 Admission MDS assessment and indicated the assessment indicating he received one insulin injection was a mistake, and she should have put zero instead. 2. The clinical record for Resident 14 was reviewed on 7/20/23 at 11:20 a.m. Her diagnoses included, but were not limited to: psychotic disorder, depression, and anxiety. The 10/31/18 PASRR (Preadmission Screening and Resident Review) Level II assessment indicated she was mentally ill. The 1/4/23 Annual MDS (Minimum Data Set) assessment indicated she was not considered by the state Level II PASRR process to have a serious mental illness. An interview was conducted with the MDSC (Minimum Data Set Coordinator) on 7/20/23 at 11:36 a.m. She indicated Resident 14's 1/4/23 Annual MDS assessment should say she was considered to have a serious mental illness by the state Level II PASRR process. She indicated the facility used the RAI (Resident Assessment Instrument) as their policy for MDS completion.		A1500 "Preadmission Screening and Resident Review (PASRR)" and N0350 "Insulin injections" of the MDS weekly x4 weeks, then twice per month x2 months, then monthly x3 months. 4. As a quality measure, the MDS Coordinator or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plans will be revised as warranted.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.			

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	(ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure that care plan meetings were conducted quarterly for 1 of 1 resident reviewed for care planning (Resident 20). Findings include: The clinical record for Resident 20 was reviewed on 7/19/23 at 9:24 a.m. The Resident's diagnosis included, but were not limited to, end stage renal disease and diabetes. A Quarterly Minimum Data Set Assessment, completed 5/10/23, indicated he was cognitively intact. He could make his needs and wants known	F 0657	F 657 – 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? -Care plan meeting completed for Resident 20. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.	08/17/2023

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	and understand what was being said to him, and that he received dialysis. During an interview on 7/19/23 at 9:24 a.m., Resident 20 indicated he had not attended any care plan meetings. During an interview on 7/21/23 at 10:20 a.m., NC (Nurse Consultant) 1 indicated the last care plan meeting note in the medical record was dated 1/23/23. During an interview on 7/21/23 at 10:45 a.m., the SSD indicated he was unaware of why a care plan meeting had not been held for Resident 20 since 1/23/23. On 7/21/23 at 11:12 a.m., the SSD provided the Resident's First Meeting Guidelines Policy, last revised 4/25/22, which read "...To facilitate communication and participation regarding the resident's plan of care, medical condition and care needs between the resident, family, residents representative and care givers...Subsequent meeting for non-Medicare Residents should be conducted at a minimum of quarterly and with significant change... Director of Social Services or designee should send invitations to the residents.... notifying them of the date and time of the conference as far in advance as possible..." 3.1-35(c)(2)		-All like residents have the potential to be affected by the alleged deficient practice. ED/DHS or designee to educate IDT (interdisciplinary team) on the "Resident's First Meeting Guidelines Policy". 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? -As a measure of ongoing compliance, ED or designee will audit quarterly care plan meetings to ensure meetings are held per policy. An audit of 5 residents will be conducted 2 times a week times 4 weeks, and then 1 time a week times x 8 weeks, and then once monthly times 3 months. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased	

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			concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. 5. Date of completion: 08/17/2023	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §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; Based on observation, interview and record review, the facility failed to provide showers as ordered for 1 of 4 residents reviewed for Activities of Daily Living (ADL). (Resident 45) Findings include: The clinical record for Resident 45 was reviewed on 7/19/23 at 1:45 p.m. The resident's diagnosis included, but was not limited to, dementia. The Admissions MDS (Minimum Data Set), completed on 4/13/23, indicated Resident 45 was severely cognitively impaired. The resident was total dependence of 1 staff person with bathing and was needing extensive assistance of one staff person with personal hygiene and dressing. An ADL care plan dated 4/18/23 indicated the resident was to receive assistance for ADL tasks.	F 0677	F 677 ADL Care Provided for Dependent Residents– 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? - Bathing preferences reviewed for resident 45. No further concerns identified at this time. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. -All residents have the potential to be affected by the alleged deficient practice. DHS or designee to	08/17/2023

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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
	The resident's clinical record did not include a care plan that included interventions in place to address refusals of showers nor preference of a bed bath instead of shower. A physician order dated 4/11/23 indicated the resident was to receive showers Mondays and Thursdays on day shift. A physician order dated 4/11/23 indicated "the resident is to be changed from day to night clothes (and vice versa) in the am (a.m.) and pm (p.m.)." An observation was made of Resident 45 on 7/18/23 at 1:43 p.m. The resident was lying in bed. During a Confidential Interview, they indicated Resident 45 does not receive his showers. The June 2023 bathing report was provided by the Corporate MDS Clinical support on 7/21/23 at 11:45 a.m. It indicated the following days resident did not receive a shower as ordered: Thursday - 6/1/23 bed bath completed, Monday - 6/5/23 bed bath completed, Thursday - 6/8/23 bathing was not provided, Monday - 6/12/23 bed bath completed, Thursday - 6/15/23 other bathing completed, Thursday - 6/22/23 - bed bath completed, Monday - 6/26/23 - partial bed bath, Thursday - 6/29/23 - partial bed bath, The June 2023 shower sheets was provided by Nurse Consultant 1 on 7/24/23 at 1:36 p.m. It indicated the following days showers were not provided: Thursday 6/1/23 - no shower sheet provided,		educate nursing staff on the policy of resident bathing preferences. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? -DHS or the designee will be responsible for auditing resident bathing preferences and documentation. An audit of 5 residents will be conducted 3 times a week times 4 weeks, and then 2 times a week times 8 weeks, and then every other week x3 months. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met.	

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	155816	A. BUILDING 00 B. WING	07/25/2023

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	Monday 6/5/23 - resident refused bathing, Thursday 6/8/23 - resident refused bathing, Monday 6/12/23 - resident refused bathing , Thursday 6/15/23 - did not specify type of bathing, Thursday 6/22/23 - bed bath completed, Thursday 6/29/23 - bed bath completed, The bathing report for July 2023 was provided by the Corporate MDS Clinical Support on 7/21/23 at 11:45 a.m. It indicated the following days showers were not provided: Monday - 7/3/23 - bathing did not occur, Monday - 7/10/23 partial bed bath, Thursday - 7/13/23 partial bed bath, The July 2023 shower sheets was provided by Nurse Consultant 1 on 7/24/23 at 1:36 p.m. It indicated the following days showers were not provided: Monday - 7/3/23 - no shower sheet provided, Thursday - 7/6/23 - Family provided shower, Monday - 7/10/23 - no shower sheet provided, Thursday 7/13/23 - bed bath completed, An interview was conducted with Nurse Consultant 1 on 7/24/23 at 1:40 a.m. She was unable to find shower sheets for some of the days. The activities staff had completed a bathing preference assessment on 5/26/23 with the resident. He preferred to receive bed baths. Resident 45's Representative was notified and was okay with the resident receiving bed baths. She was unsure why the clinical record had a physician order to ensure showers were completed on Mondays and Thursdays. The resident's clinical record did not include		5. Date of completion: 08/17/2023	

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	documentation Resident 45's Representative was aware of the resident's preference of bed baths instead of showers. The physician order to receive showers on Mondays and Thursdays was not discontinued. 3.1-38(a)(2)(a)			
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to timely address a resident's lower extremity edema, timely schedule an orthopedic appointment, to obtain blood sugar readings and administer insulin before meals as ordered, and failed to hold insulin when blood sugar results were below 110, as ordered by the physician, for 1 of 1 resident reviewed for edema, 1 of 3 residents reviewed for ADLs (activities of daily living), 1 of 1 resident reviewed for insulin, and 1 of 5 residents reviewed for unnecessary medications (Residents 5, 14, 31, and 38) Findings include: 1. The clinical record for Resident 38 was reviewed on 7/18/23 at 2:00 p.m. Her diagnoses included, but were not limited to, polyneuropathy. The 7/15/23 skilled nursing assessment indicated	F 0684	F 684 Quality of Care – 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? -Resident 5 and Resident 38 have been discharged. - Resident 31 orders reviewed resident receiving glucose checks and insulin as ordered. - Resident 14 orders reviewed resident receiving glucose checks and insulin as ordered. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. -All like residents have the	08/17/2023

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	she had +1 pitting edema (up to 2 mm of depression, rebounding immediately) in her left and right lower legs. There was no information, including in the progress notes or physician's orders, in the clinical record indicating the lower extremity edema was addressed or that the physician was notified. The 6/6/23 Admission MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status) score of 14, indicating she was cognitively intact. An interview and observation was conducted with Resident 38 on 7/18/23 at 2:18 p.m. She was sitting in her wheel chair in her room. She was wearing ballet type slippers. Both feet were puffy. She was not wearing any tubi-grips or compression stockings. Resident 38 took off her left slipper to display how swollen her foot was. She indicated her feet were swollen, and she couldn't put on her shoes. She informed nursing last week, on 7/13/23, but it hadn't been addressed. Her feet hurt when she stood up and put pressure on them. She'd tried to put on her shoes twice since 7/13/23, but was unable to get them on, because they were too swollen, and she didn't want to force them into her shoes. Nursing was informed of Resident 38's edema concerns immediately after the above interview. The 7/18/23 physician's order read, "Apply tubi-grip to BLE [bilateral lower extremities] each morning before rising. Remove ted hose at bedtime Twice A Day." An interview and observation was conducted with Resident 38 on 7/19/23 at 3:22 p.m. She was sitting in her wheel chair in her room. She was		potential to be affected by the alleged deficient practice. DHS or designee to educate nursing staff on “Medication Administration General Guidelines” and “Notification of Change in Condition Policy”. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? - DHS or designee will be responsible for auditing residents receiving insulin to ensure administration is as ordered. An audit of 5 residents will be conducted 3 times a week times 4 weeks, 2 times a week times 8 weeks and then every other week x 3 months. - DHS or designee will be responsible for auditing residents with new onset of edema to ensure physician is notified with appropriate documentation. An audit of 5 residents will be conducted 3 times a week times 4 weeks, 2 times a week times 8 weeks and then every other week x 3 months. -DHS or designee will be responsible for auditing residents with referrals for new ortho appointments to ensure appointments have been scheduled. An audit of 5 residents will be conducted 3 times a week times 4 weeks, 2 times a week times 8 weeks and	

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	wearing tubi-grips on both legs/feet with gripper socks over them. Resident 38 indicated nursing put the tubi-grips on her yesterday before dinner and they'd been on ever since. They were itchy and starting to hurt. No one removed them last night at bedtime, and she didn't know they were supposed to be removed. An interview was conducted with QMA (Qualified Medication Aide) 2 on 7/19/23 at 3:46 p.m. He indicated he thought the ted hose portion of the order may be a typo and that her tubi-grips should have been taken off last night, as they typically remove a resident's tubi-grips at night. The 7/18/23, 4:48 p.m. nurse's note, recorded as a late entry by LPN (Licensed Practical Nurse) 6 on 7/19/23 at 4:57 p.m., read, "resident requests compression hose due to edema in bilateral lower extremities. NP [Nurse Practitioner] made aware. New orders for tubi-grips to BLE until ted hose arrive. Resident made aware and verbalizes understanding." The 7/20/23 NP note read, "...The chief complaint for this visit is Medical Management - BLE Edema...Nursing requested resident be seen for increasing BLE edema, TED hose have been ordered. She has history of seizure disorder, she denies cough, shortness of breath or other concern, denies numbness or tingling. She 2+ pitting edema to BLE and feet. Orders placed for Torsemide 20 mg daily. During the visit she is alert and oriented, appears comfortable...Skin: Warm, Dry, Fragile, toe infection. Extremities: PPP [progressive pigmented purpura], Edema +:2, BLE...Assessment/Treatment Plan Diagnosis R600: Localized edema (Start Torsemide 20 mg daily)...Verification of Necessity: In my judgement as the physician/provider, the care provided		then every other week x 3 months. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. 5. Date of completion: 08/17/2023	

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	today required professional assessment, planning, management, or monitoring." 2. The clinical record for Resident 5 was reviewed on 7/19/23 at 9:45 a.m. Her diagnoses included, but were not limited to: acute kidney failure, polyneuropathy, chronic obstructive pulmonary disease, morbid obesity, hyperlipidemia, atrial flutter, depression, spinal stenoises, hypertension, lymphedema, and degenerative joint disease. The 7/7/23 functional impairment care plan for Resident 5 indicated she required extensive/total assistance with transfers, bed mobility, and toileting, keeping in mind that ADL ability could fluctuate frequently. The 7/4/23 Admission MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status) score of 14, indicating she was cognitively intact. The 7/20/23, 6:04 a.m. nurse's note read, "Resident states, 'left great toe was in pain and that resident's toe was hit on door during transfer from Bingo on 7/19/23." redness, swelling and unable to do ROM [range of motion] on left great toe. PRN [as needed] pain med given and effective. New order noted for STAT [without delay] Left foot Xray x [times] 3 views complete. Notifications made." The 7/20/23, 2:55 p.m. nurse's note, written by LPN (Licensed Practical Nurse) 6 read, "left toe xr [x-ray] result sent to NP [nurse practitioner.] new orders for WBAT [weight bearing as tolerated,] wrap with kerlix as tolerated and referral to ortho [orthopedics.] resident made aware. verbalizes understanding."			

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	The physician's orders indicated a referral to ortho for fracture of distal 1st phalanx, starting 7/20/23. There was no information in the clinical record indicating an orthopedic appointment was scheduled for her. An interview was conducted with LPN 6 on 7/25/23 at 1:05 p.m. She indicated she spoke with Resident 5 about an orthopedic appointment on 7/20/23. Resident 5 informed her she would let her know which orthopedic physician/clinic she would like to use, but Resident 5 hadn't yet let her know, and LPN 6 hadn't followed up with her about the appointment since. LPN 6 went into Resident 5's room "all the time." An interview was conducted with Resident 5 on 7/25/23 at 1:15 p.m. She indicated no one had discussed anything with her about an orthopedic appointment. If the facility was supposed to set one up, she didn't know about it. She was supposed to be leaving the facility to go home this coming Friday. She would be fine with the facility choosing an orthopedic physician for her and setting up the appointment, even if the appointment was scheduled for after she went home. 3. The clinical record for Resident 31 was reviewed on 7/19/23 at 10:45 a.m. The resident's diagnoses included, but was not limited to, end stage renal disease and type 2 diabetes. The Quarterly MDS (Minimum Data Set), completed on 6/18/23, indicated Resident 31 was cognitively intact. A physician order dated 6/9/23 indicated Resident 31 was to receive a sliding scale of humalog			

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	insulin before each meal. The humalog insulin sliding scale was the following: blood sugar reading of 151 to 200 = 2 units of insulin, blood sugar reading of 201 to 250 = 4 units of insulin, blood sugar reading of 251 to 300 = 6 units of insulin, blood sugar reading of 301 to 350 = 8 units of insulin, and blood sugar greater than 351 medical provider was to be notified The July 2023 Medication Administration Record indicated the following days and meals the staff had not obtained a blood sugar reading to administer insulin if appropriate to Resident 31: 7/3/23 - dinner meal - no reason given, 7/15/23 - breakfast meal - staff documented "unavailable", 7/19/23 - dinner meal - staff documented "unavailable", and 7/21/23 - lunch meal - staff documented "LOA" (leave of absence) The July 2023 Intake Report for Resident 31 indicated the following days, and the percentages of the meal the resident had eaten: 7/3/23 - dinner meal = 26-50%, 7/15/23 - breakfast meal = 76-100%, 7/19/23 - dinner meal = 76-100% and 7/21/23 - lunch meal = 76-100% An interview was conducted with Resident 31 prior to the noon lunch meal in the community activities room on 7/21/23 at 11:17 a.m. Resident 31 indicated she was to receive insulin 3 times a day,			

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	but she does not receive the insulin at times due to not being on the unit. She attends activities and hangs out in the front lobby to socialize with peers most days. The nursing staff have told her if she was not on the unit at the time of insulin administration they were not going to "hunt" her down, even though she has observed her peers receiving medications while they are off the unit. During an interview with Director of Nursing on 7/26/23 at 1:00 p.m., the nursing staff had attempted to obtained the 7/21/23 lunch meal blood sugar reading, but it was after the lunch meal. The resident was outside at that time. 4. The clinical record for Resident 14 was reviewed on 7/19/23 at 11:03 a.m. The Resident's diagnosis included, but were not limited to, diabetes and anemia. A care plan, initiated 11/7/2019, indicated Resident 14 was at risk for hypo (low) and hyperglycemia (high blood sugar) due to her diagnosis of diabetes. The goal was for her to be free of symptoms of hypo/hyperglycemia. The interventions included, monitor blood sugars as ordered by the physician and to administer medications per physician's orders, initiated 11/7/2019. A physician's order, dated 12/21/22, indicated Resident 14 was to receive Basaglar insulin 24 units each evening between 7:00 p.m. and 10:00 p.m. The insulin was to be held if her blood sugar was below 110. The June and July 2023 MAR (Medication Administration Records) indicated the 24 units of Basaglar insulin was administered as follows: 6/7/23- 24 units administered- blood sugar recorded was 108,			

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	6/8/23- 24 units administered- blood sugar recorded was 85, 6/17/23- 24 units administered- blood sugar recorded was 101, and 7/17/23- 24 units administered- blood sugar recorded was 98. During an interview on 7/24/23 at 2:02 p.m., LPN (Licensed Practical Nurse) 11 indicated that when a physician's order indicated to hold insulin for a blood sugar below 110, the dose of insulin should not be given when blood sugars are below 110. 3.1-37			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure fall interventions were implemented for 1 of 2 residents reviewed for falls and failed to properly orient and train volunteers, who would be assisting residents with mobility affecting 1 of 3 residents reviewed for ADLs (activities of daily living) (Resident 5 and 45) Findings include: 1. The clinical record for Resident 45 was reviewed	F 0689	F 689 Free of Accident Hazards/Supervision/Devices– 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? -Resident 5 has discharged - Resident 45 has fall interventions in place per plan of care. 2: How other residents having the	08/17/2023

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	on 7/19/23 at 1:45 p.m. The resident's diagnosis included, but was not limited to, dementia. The Admissions MDS (Minimum Data Set), completed on 4/13/23, indicated Resident 45 was severely cognitively impaired. A fall care plan dated 4/6/23 indicated Resident 45 was a risk for falling and needed assistance with mobility. The interventions put in place for fall prevention included but was not limited to, non skid socks initiated on 4/10/23, visual signage to use call light initiated on 6/24/23, non slip grip to wheelchair seat initiated on 6/27/23, and urinal at bedside initiated on 7/12/23. A fall event dated 6/24/23 indicated the resident had a fall while transferring self to toilet without assistance. The resident was attempting to self transfer to toilet. The new interventions put in place was for visual reminders to use call light for assistance. A fall event dated 6/27/23 indicated the resident had a fall while transferring self to toilet without assistance. The resident was found sitting on floor of the bathroom with wheelchair. The resident had slipped out of the wheelchair. The new intervention was for non-slip grip to wheelchair seat. A fall event dated 7/2/23 indicated the resident had an unwitnessed fall on 7/2/23. It indicated resident had fallen in the bathroom. The root cause was the resident self transfers to the toilet without assistance. The new interventions put in place was urinal to be placed at bedside. Observations were made of the resident in his room on 7/18/23 at 1:43 p.m., and 7/20/23 at 10:35		potential to be affected by the same deficient practice will be identified and what corrective action will be taken. -All like residents have the potential to be affected by the alleged deficient practice. DHS or designee to educate nursing staff on the “Fall Management Program Guidelines”. ED or designee will educate the LED (life enrichment director) and activities staff on the Volunteer policy. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? -DHS or designee will be responsible for auditing residents with falls to ensure interventions are in place. An audit of 5 residents will be conducted 3 times a week times 4 weeks, 2 times a week times 8 weeks and then every other week x 3 months. -LED or designee will audit volunteers to ensure training is completed per policy. An audit volunteer orientation files will be conducted weekly times 4 weeks, every 2 weeks times 4 weeks, then monthly x 4 months. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what	

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	a.m. The resident was observed lying in his bed. The resident was not wearing non skid socks nor a urinal was placed at bedside. An observation made of Resident 45 in his room with Qualified Medication Assistant (QMA) 2 on 7/20/23 at 11:07 a.m. The resident was observed lying in bed with white socks on that were not non slip, and there was no urinal observed at bedside. QMA 2 indicated at that time, the resident had been wearing shoes prior to placement in bed, so the staff would not have put non-slid socks on at that time. QMA 2 was able to locate a urinal in the bathroom. 2. The clinical record for Resident 5 was reviewed on 7/19/23 at 9:45 a.m. Her diagnoses included, but were not limited to: acute kidney failure, polyneuropathy, chronic obstructive pulmonary disease, morbid obesity, hyperlipidemia, atrial flutter, depression, spinal stenosis, hypertension, lymphedema, and degenerative joint disease. The 7/7/23 functional impairment care plan for Resident 5 indicated she required extensive/total assistance with transfers, bed mobility, and toileting, keeping in mind that ADL ability could fluctuate frequently. The 7/4/23 Admission MDS (Minimum Data Set) assessment indicated she required limited assistance (resident highly involved in activity, staff providing guided maneuvering of limbs or other non weight bearing assistance) of one staff person for locomotion on and off the unit. She had a BIMS (brief interview for mental status) score of 14, indicating she was cognitively intact. The 7/20/23, 6:04 a.m. nurse's note read, "Resident states, 'left great toe was in pain and that		quality assurance program will be put into place? For quality assurance, The ED/DHS/ADHS/Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. 5. Date of completion: 08/17/2023	

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	155816	A. BUILDING 00 B. WING	07/25/2023

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	resident's toe was hit on door during transfer from Bingo on 7/19/23." redness, swelling and unable to do ROM [range of motion] on left great toe. PRN [as needed] pain med given and effective. New order noted for STAT [without delay] Left foot Xray x [times] 3 views complete. Notifications made." The 7/20/23, 2:55 p.m. nurse's note, written by LPN (Licensed Practical Nurse) 6 read, "left toe xr [x-ray] result sent to NP [nurse practitioner.] new orders for WBAT [weight bearing as tolerated,] wrap with kerlix as tolerated and referral to ortho [orthopedics.] resident made aware. verbalizes understanding." An interview was conducted with Resident 5 on 7/25/23 at 1:15 p.m. She indicated one of the younger male volunteers who was in the facility last week was pushing her back into her room and her left foot hit the side of the doorway. Her foot was on the foot pedal at the time. When it hit, it didn't hurt too bad, but then once in her room after 30 or 40 minutes, it started throbbing and sweating. She had on a sock and it took her and a staff member to get it off, because it hurt that bad to even have it touched with a sock. It felt better now, but she still had a "twinge of pain." The volunteer group in the facility were all very helpful, and she didn't blame the young volunteer for her broken toe. An interview was conducted with the AD (Activity Director,) DON (Director of Nursing,) and ED (Executive Director) on 7/25/23 at 2:23 p.m. The AD indicated a specific organization was currently volunteering in the facility for several weeks this summer from 6/24/23 through 7/27/23. The organization sent 5-7 volunteers, including 5 children under the age of 18 with 2 adults, weekly.			

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	The AD did an orientation and tour with the organization's group leader in approximately May, 2023 and sent a volunteer packet for completion. She spoke with the group leader over the phone about any requirements and types of activities the campers would be doing. The individual campers didn't go through any type of training. The AD would give the group a list of activities to do each day like watering plants in the courtyards, talking with residents, one on one activities with residents such as playing cards or board games. One resident watched a movie in the movie room with a camper. Campers also assisted in transporting residents in their wheel chairs to and from their rooms. The campers did not receive specific training on transporting them in their wheel chairs, but the AD would inform the campers if they felt uncomfortable doing anything, like putting a resident's feet on their wheelchair pedals, to come and find a staff member. The AD gave a copy of the Volunteer Handbook and volunteer application to the head person from the organization, but did not give each camper an application or handbook. The AD did not go over the Volunteer Handbook with campers. The AD provided a copy of the Volunteer Handbook on 7/25/23 at 2:50 p.m. The Key Points portion of the handbook had a section entitled Wheelchair Safety that read, "When working with and/or transporting residents in wheelchairs, please follow the [name of facility] safety procedures for your own safety as well as the safety of the resident....Enter and exit an area slowly, making sure that you look in all directions. There is a danger of running into other residents if caution is not used. Do not cut corners. Keep the resident's arms and hands within the chair-watch elbows when rounding a corner. Make sure the			

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	resident's feet are securely on the pedals." An interview was conducted with Volunteer 9 on 7/25/23 at 3:05 p.m. in the activity room. She indicated she arrived at the facility this week to volunteer. No one had given her the Volunteer Handbook or went over it with her. Their contact person from their organization informed their group where to show up, discussed appropriate dress, but nothing about transporting residents in their wheel chair. The Volunteer policy was provided by the ED on 7/25/23 at 3:10 p.m. The ED indicated the organization currently volunteering in the facility were considered visitors, not volunteers. It read, "A volunteer is a community member who seeks involvement with the Campus specifically to complete a volunteer task that may include 1-1 contact with a resident. They: Complete a volunteer application...Receive a volunteer welcome packet...In contrast, a visitor is a community member who enters the Campus primarily to be with a loved one, or to provide very infrequent visits for the residents with no or minimal interaction....Each volunteer/group will be interviewed, oriented, trained, and supervised." A fall policy was provided by Nurse Consultant 2 on 7/20/23 at 1:30 p.m. It indicated "...Purpose Trilogy health Services (THS) strive to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. THS recognizes even the most vigilant efforts may not prevent all falls and injuries. In those cases, intensive efforts will be directed toward minimizing or preventing injury...Procedure: 1. The fall risk assessment is included as part of the Admission and Quarterly Nursing Observation and other Events/Observations in EHR [Electronic			

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	Health Record]: a. Identified risk factors should be evaluated for the contribution they may have to the resident's likelihood of falling. b. Care plan interventions should be implemented that address the resident's risk factors..." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to hold a dose of intravenous vancomycin (antibiotic) as instructed by the pharmacy and to communicate the status of needed vancomycin level results to the pharmacy and physician so that an ordered dose of intravenous vancomycin could be administered for 1 of 1 resident reviewed for dialysis (Resident 20). Findings include: The clinical record for Resident 20 was reviewed on 7/19/23 at 9:24 a.m. The Resident's diagnosis included, but were not limited to, end stage renal disease and diabetes. He was admitted to an acute care hospital on 7/1/23 and returned to the facility following hospitalization on 7/4/23. A Quarterly Minimum Data Set Assessment, completed 5/10/23, indicated he was cognitively intact. He could make his needs and wants known and understand what was being said to him, and that he received dialysis. An acute care hospital physician's progress note,	F 0760	F 760 Residents are Free of Significant Med Errors– 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? -Resident 20 orders reviewed, vancomycin has been discontinued, no adverse effects noted. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. -All like residents have the potential to be affected by the alleged deficient practice. DHS or designee to educate nursing staff on “Provider Notification Guidelines”. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	08/17/2023

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	dated 7/4/23 at 2:01 p.m. read "...patient who presented with complaints of fever and was admitted with a principle diagnosis of Sepsis without acute organ dysfunction, due to unspecified organism...febrile state noted to resolve with antibiotic use...right femoral dialysis access was removed 7/3, patient to be on vancomycin for 1 week after, discharge 07/05 when we are sure his dialysis center his[sic] going to go to their[sic] aware of need for 1 week of vancomycin..." The Current Discharge Medication List sent from the acute care hospital on 7/4/23 indicated Resident 20 was to receive vancomycin in dextrose 5% (type of intravenous fluid) 1 gram/250 ml (milliliter). Inject 1,000 mg into the vein 3 time a week for 4 days. Give after dialysis, on dialysis days only (Tuesday, Thursday, and Saturday). Start taking on July 6, 2023. A nursing progress note, dated 7/4/23 at 9:53 p.m., indicated that Resident 20 was alert and oriented times 3 and had returned from the hospital with an order for vancomycin intravenous which was to be administered at dialysis. A physician's order dated 7/6/23 indicated a vancomycin trough level was to be drawn on 7/6/23 before Resident 20 received dialysis. A physician's order, dated 7/6/23, indicated vancomycin 1,000 mg was to be given intravenously at dialysis. This order was placed on hold on 7/7/23 and discontinued on 7/8/23. An Outpatient Dialysis Flowsheet, dated 7/6/23, indicated that at 8:40 a.m., Resident 20 had received 1,000 mg of vancomycin IV (Intravenously).		- DHS/ADHS or designee will be responsible for auditing residents receiving IV antibiotics to ensure lab results are reported to physician as warranted. An audit of 3 residents will be conducted 3 times a week times 4 weeks, 2 times a week times 8 weeks and then every other week x 3 months. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED/DHS/ADHS or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. 5. Date of completion: 08/17/2023	

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	A lab report, dated 7/7/23, indicated that the vancomycin trough, collected on 7/6/23, was unsatisfactory due to improper collection tube received. Please enter a new order and recollect. The July 2023 MAR (Medication Administration Record) indicated that the 7/8/23 dose of vancomycin 1,000 mg was placed on hold. A physician's order, dated 7/8/23, indicated a vancomycin peak and a vancomycin trough were to be drawn on 7/8/23 due to a sample error. A Dialysis Center Communication Form, dated 7/8/23, indicated that Vancomycin 1 gram (1,000 mg) was administered IV at dialysis. A physician's order, dated 7/11/23, indicated to send a plain red top tube to dialysis for lab work on 7/11/22. A Lab Report, dated 7/12/23, indicated a vancomycin trough level was critically high at 22.5. A physician's order, dated 7/13/23, indicated a vancomycin trough level was to be done and may be processed as STAT (right away). A nursing progress note dated 7/13/23 at 5:55 a.m. read "...Sent tubes for lab draw for stat vancomycin trough. Dialysis drew labs. Specimens properly inverted and centrifuged according.[sic] Pending labs to be picked up." During an interview on 7/21/23 at 2:02 p.m., LT (Lab Technician) 20 indicated the lab had received a blood sample for a vancomycin trough level on			

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	7/6/23, which they were unable to process. The lab has also received a blood sample for vancomycin trough which was drawn on 7/11/23. The lab received it on 7/12/23 via a courier service since the lab itself is located in another state. The critically high results of the 7/11/23 vancomycin level had been called to the facility on 7/12/22 at 2:17 p.m. The lab had not received any other blood samples for vancomycin levels on Resident 20. The lab does not perform vancomycin peak levels and does not perform "STAT" lab orders for the facility because of being too far away from the facility to perform these tests timely. During an interview on 7/21/23 at 3:03 p.m., NC (Nurse Consultant) 11 indicated that when a lab is ordered "STAT" the facility would call the lab and the lab would arrange a courier to take the sample to a local hospital to be completed. During an interview on 7/24/23 at 10:30 a.m., RP (Registered Pharmacist) 21 indicated the pharmacy had sent two 1 gram doses of vancomycin to the facility on 7/5/23. The pharmacy was to adjust the vancomycin doses based on Resident 20's vancomycin levels. On 7/5/23, the pharmacy had inquired about a stop date for the vancomycin and was sent a progress note which indicated that the vancomycin should have been given for 4 days. A 7/11/23 vancomycin trough level of 22.5 had been received by the pharmacy. RP 21 had called the facility on 7/17/23 to inquire if there were any other vancomycin trough levels available so that she could adjust the next dose of vancomycin which Resident 20 was to receive. There were no other vancomycin trough levels available. The dose the provider had wanted Resident 20 to receive had not been provided by the pharmacy due to vancomycin levels not being available for dosing.			

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	During an interview on 7/25/23 at 12:34 p.m., NP (Nurse Practitioner) 22 indicated she had been informed that the 7/6/23 vancomycin trough level was unable to be completed by the lab. She had told the facility she would suggest not administering the vancomycin to Resident 20 on 7/8/23, but had the facility call the pharmacy, since the pharmacy was adjusting the dosage of vancomycin. The pharmacy had agreed the 7/8/23 dose of vancomycin should have been held. The 7/8/23 vancomycin dose should not have been given. She had not been informed that the vancomycin dose was administered on 7/8/23, but she would have liked to have known. On 7/12/23, NP 22 had been informed of the critically high vancomycin trough level and had instructed the facility to let the pharmacy know. On 7/25/23 at 3:39 p.m., the Director of Nursing Services provided the Medication Administration Policy, last revised November 2018, which read "...Medications are administered in accordance with written orders of the prescriber..." On 7/25/23 at 1:12 p.m., Nurse Consultant 2 provided the Provider Notification Guidelines Policy, last reviewed 12/31/22, which read "...To ensure the resident's physician or practitioner....is aware of all diagnostic testing results or change in condition in a timely manner to evaluate conditions for need of provision of appropriate interventions of care...ordered lab and/or other diagnostic tests should be completed in a timely manner...all other test results or order request may be faxed to the physician/provider's office during office hours...Faxed test results or order requests should indicate the staff member's name sending the results request and the time sent...Attempts to notify the physician/ provider and their response			

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	should be documented in the resident electronic health record..." 3.1-48(c)(2)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on interview and record review, the facility failed to timely obtain lab, as ordered by a physician, and to timely report lab results to providers for 1 of 1 resident reviewed for dialysis (Resident 20). Findings include: The clinical record for Resident 20 was reviewed on 7/19/23 at 9:24 a.m. The Resident's diagnosis included, but were not limited to, end stage renal disease and diabetes. He was admitted to an acute care hospital on 7/1/23 and returned to the facility following hospitalization on 7/4/23. A Quarterly Minimum Data Set Assessment, completed 5/10/23, indicated he was cognitively intact. He could make his needs and wants known and understand what was being said to him, and that he received dialysis. The Current Discharge Medication List sent from the acute care hospital on 7/4/23 indicated	F 0770	F 770 Laboratory Services– 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? -Resident 20's antibiotic is complete with no adverse effects noted. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. -All residents like residents have the potential to be affected by the alleged deficient practice. DHS or designee to educate nursing staff on "Provider Notification Guidelines" and "Ordering Lab Tests". 3: What measures will be put into place or what systemic changes will be made to ensure that the	08/17/2023

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	Resident 20 was to receive vancomycin in dextrose 5% (type of intravenous fluid) 1 gram/250 ml (milliliter). Inject 1,000 mg into the vein 3 time a week for 4 days. Give after dialysis, on dialysis days only (Tuesday, Thursday, and Saturday). Start taking on July 6, 2023. A physician's order, dated 7/8/23, indicated a vancomycin peak and a vancomycin trough were to be drawn on 7/8/23 due to a sample error. A physician's order, dated 7/11/23, indicated to send a plain red top tube to dialysis for lab work on 7/11/22. A Lab Report, dated 7/12/23, indicated a vancomycin trough level was critically high at 22.5. A physician's order, dated 7/13/23, indicated a vancomycin trough level was to be done and may be processed as STAT (right away). A nursing progress note dated 7/13/23 at 5:55 a.m. read "...Sent tubes for lab draw for stat vancomycin trough. Dialysis drew labs. Specimens properly inverted and centrifuged according. [sic] Pending labs to be picked up." During an interview on 7/21/23 at 2:02 p.m., LT (Lab Technician) 20 indicated the lab had received a blood sample for a vancomycin trough level on 7/6/23, which they were unable to process. The lab has also received a blood sample for vancomycin trough which was drawn on 7/11/23. The lab received it on 7/12/23 via a courier service since the lab itself is located in another state. The critically high results of the 7/11/23 vancomycin level had been called to the facility on 7/12/22 at 2:17 p.m. The lab had not received any other		deficient practice does not recur? - DHS/ADHS or designee will be responsible for auditing residents receiving IV antibiotics to ensure lab results are reported to physician as warranted. An audit of 3 residents will be conducted 3 times a week times 4 weeks, 2 times a week times 8 weeks and then every other week x 3 months. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns are noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance is met. 5. Date of completion: 08/17/2023	

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	blood samples for vancomycin levels on Resident 20. The lab does not perform vancomycin peak levels and does not perform "STAT" lab orders for the facility because of being too far away from the facility to perform these tests timely. During an interview on 7/24/23 at 10:30 a.m., RP (Registered Pharmacist) 21 indicated the pharmacy was to adjust the vancomycin doses based on Resident 20's vancomycin levels. A 7/11/23 vancomycin trough level of 22.5 had been received by the pharmacy. RP 21 had called the facility on 7/17/23 to inquire if there were any other vancomycin trough levels available so that she could adjust the next dose of vancomycin which Resident 20 was to receive. There were no other vancomycin trough levels available. On 7/25/23 at 1:12 p.m., Nurse Consultant 2 provided the current Ordering Lab Tests Policy which read "...STAT lab testing is prioritized over routine testing, and will be done in an expedited and timely manner. Stat eligible tests include...Therapeutic Drug Monitoring Tests [Vancomycin...] ...Once the specimen has been collected, call ...Customer Care Team to arrange for transport of your STAT specimen[s] to the STAT partner with which we contracted for you...Results for STAT testing are reported within 4 hours of contacted[sic].... for your request for STAT testing...all results for STAT testing will be faxed to your location by the STAT provider and/or .... upon completion..." On 7/25/23 at 1:12 p.m., Nurse Consultant 2 provided the Provider Notification Guidelines Policy, last reviewed 12/31/22, which read "...To ensure the resident's physician or practitioner....is aware of all diagnostic testing results or change in condition in a timely manner to evaluate			

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	155816	A. BUILDING 00 B. WING	07/25/2023

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	conditions for need of provision of appropriate interventions of care...ordered lab and/or other diagnostic tests should be completed in a timely manner...all other test results or order request may be faxed to the physician/provider's office during office hours...Faxed test results or order requests should indicate the staff member's name sending the results request and the time sent...Attempts to notify the physician/ provider and their response should be documented in the resident electronic health record..." 3.1-49(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00410442 and Complaint IN00409997. Complaint IN00410422- No deficiencies related to the allegations are cited. Complaint IN00409997- No deficiencies related to the allegations are cited. Survey dates: July 18, 19, 20, 21, 24, and 25, 2023. Facility number: 013005 Residential Census: 11 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 3, 2023	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Recertification and State Licensure Survey and Investigation of Complaint IN00410442 and Complaint IN00409997 conducted July 18, 2023 through July 25, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of August 17, 2023. The provider respectfully requests desk	

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			review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure the service plan was signed by the resident or resident's representative and failed	R 0217	R 217 Evaluation– 1: What corrective action(s) will be accomplished for those residents	08/17/2023

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	to review the service plan with a resident for 2 of 5 resident's records reviewed. (Resident 2 and Resident 8) Findings include: 1. The clinical record for Resident 8 was reviewed on 7/25/23 at 1:45 p.m. The resident's diagnosis included, but was not limited to, wedge compression fracture of second lumbar vertebra. A service plan dated 7/14/22 indicated the services to be provided for Resident 8. The Service plan did not include the resident's signature. An interview was conducted with the Director of Nursing Services (DNS) on 7/25/23 at 4:24 p.m. She indicated she was unable to provide a service plan that had been signed by the resident. 2. The clinical record for Resident 2 was reviewed on 7/25/23 at 10:38 a.m. The Resident's diagnosis included, but were not limited to, congestive heart failure. A Legacy Evaluation and Service Plan, dated 10/21/22, indicated Resident 2 was cognitively intact. The Service Plan was not signed by Resident 2. During an interview on 7/25/23 at 11:30 a.m., Resident 2 indicated he had never been to a service plan meeting or had his service plan explained to him. On 7/25/23 at 2:18 p.m., the Director of Nursing Services provided the Assisted Living Evaluation and Service Plan Guidelines Policy, last reviewed 3/24/22, which read "...A service plan shall be identified and implemented in response to the		found to have affected by the deficient practice? - Residents 2 and 8 have had updated service plans completed and have been reviewed and signed by the resident or representative. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. -All residents have the potential to be affected by the alleged deficient practice. ED or designee to educate IDT team on the "Assisted Living Evaluation and Service Plan Guidelines Policy". 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? -DAL or designee will be responsible for auditing assisted living residents to ensure service plans are up to date per policy and have been reviewed with and signed by the resident or representative. An audit of 5 residents will be conducted 2 times a week times 4 weeks, and then 1 time a week times x 8 weeks, and then once monthly times 3 months. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?	

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	resident's evaluation and in collaboration with the resident and/or responsible party. The Assisted Living Director or designee will discuss the services he/she requires..."		For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. 5. Date of completion: 08/17/2023	
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for			

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	tuberculosis. Based on interview and record review, the facility failed to ensure a resident that had been discharged to another health care facility was provided with a transfer form that included: name of the transitioning facility and dated of transfer, resident's personal property when transferred to an acute care facility, nurse's notes related to the resident's functional abilities and physical limitations, nursing care, and condition of the resident at the time of the transfer for 1 of 2 residents reviewed for discharge. (Resident 2) Findings include: The clinical record for Resident 2 was reviewed on 7/25/23 at 3:45 p.m. The resident's diagnosis included, but was not limited to, schizoaffective disorder. A medical provider nursing noted dated 6/12/23 indicated "He is normally alert and oriented x's [times] 3, ambulates indep [independently], but he began to exhibit aggressive behaviors, yelling and throwing his objects away, cursing, and appeared to be upset with family last week. Psych was called, and increased Seroquel to TID [three times a day]. Today provider asked to see resident due to change in condition. He is alert and wake, he is not responding verbally to questions, able to stand and go to BR [bathroom], he is not eating or drinking. Does not appear to be agitated. Nursing informed to have psych eval [evaluation] asap, Seroquel was held for 24 hours, and decreased dose to BID [twice a day]..." The resident's clinical record indicated Resident 2 was discharged on 6/12/23 for evaluation. The transfer paperwork was provided by the	R 0354	R 354 Clinical Records– 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice? -Resident 2 remains discharged to another health care facility at this time. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. -All residents discharged to another health care facility have the potential to be affected by the alleged deficient practice. DHS or designee to educate nursing staff on the process when discharging assisted living residents to another health care facility. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? - DAL or designee will be responsible for auditing residents discharged from AL to another health care facility. An audit of 5 residents will be conducted 2 times a week times 4 weeks, and then 1 time a week times x 8 weeks, and then once monthly times 3 months. 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be	08/17/2023

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	Director of Nursing Services (DNS) on 7/25/23 at 4:15 p.m. It did not include the following information that was needed to be provided to the receiving health care facility: name of the transitioning facility and dated of transfer, resident's personal property when transferred to an acute care facility, nurse's notes related to the resident's functional abilities and physical limitations, nursing care, and condition of the resident at the time of the transfer. An interview was conducted with the DNS on 7/25/23 at 4:22 p.m. She indicated she was unable to provide any additional paperwork that was sent with Resident 2 at that time of discharge to another health care facility.		put into place? For quality assurance, The ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. 5. Date of completion: 08/17/2023	