| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155334 | A. BUILDING 00<br>B. WING | 09/14/2023 |

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| WILDWOOD HEALTHCARE CENTER | 7301 E 16TH ST<br>INDIANAPOLIS, IN 46219 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: September 6, 7, 8, 11, 12, 13, and 14, 2023.<br><br>Facility number: 000227<br>Provider number: 155334<br>AIM number: 100267520<br><br>Census bed type:<br>SNF/NF: 142<br>Total: 142<br><br>Census payor type:<br>Medicare: 8<br>Medicaid: 109<br>Other: 25<br>Total: 142<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on September 22, 2023 | F 0000 | On September 14, 2023 an annual recertification<br>survey from ISDH was completed at Wildwood<br>Healthcare. Enclosed please find the stated list of the deficiency with<br>the facility's plan of correction for this alleged deficiency.<br>Please consider this letter and plan of correction to be the facility's credible allegation of compliance. This letter is our request for a desk review/ paper compliance to verify the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the plan of correction as October 27, 2023<br><br>Respectfully<br>Ethan Peak, Executive Director | |
| F 0550<br>SS=E<br>Bldg. 00 | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights<br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for | | | |

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

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| | 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.<br><br>§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.<br><br>§483.10(b) Exercise of Rights.<br>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.<br><br>§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.<br><br>§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 review, the facility failed to maintain the dignity of residents in the facility for 4 of 7 residents reviewed for dignity. (Residents 20, 37, 54, and 64)<br><br>Findings include: | F 0550 | A) Residents 20, 37, 54, and 64 were not harmed by the deficient practice. Residents 20, 37, 54, and 64 have all been seen by social services and are at their psychosocial baseline.<br>B) All residents have the potential to be affected by the deficient | 10/27/2023 |

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| | 1. The clinical record for Resident 37 was reviewed on 9/6/23 at 1:45 p.m. Her diagnoses included, but were not limited to, intellectual disabilities, borderline personality disorder, and anxiety disorder.<br><br>The 8/15/23 Quarterly MDS (Minimum Data Set) assessment indicated Resident 37 had a BIMS (brief interview for mental status) score of 13, indicating she was cognitively intact.<br><br>An interview was conducted with Resident 37 on 9/6/23 at 1:55 p.m. She indicated one of the CNAs (Certified Nursing Assistants) "talk to me crazy," and gave a physical description of the CNA. The CNA accused Resident 37 of "always messing around." Resident 37 informed another CNA, CNA 25, about it and stated, "I tell her all the time." Resident 37 indicated she told the nurses about it too, and "they say she's all right." Resident 37 had not discussed her treatment by this CNA with the social services department and no one had followed up with her about it after informing nursing.<br><br>An interview was conducted with CNA 25 on 9/13/23 at 3:24 p.m. She indicated Resident 37 hadn't said anything to her about other staff being rude lately. Resident 37 informed her she'd rather have her as an aide, because she wasn't always assigned to her, but Resident 37 never told her any specific staff member was rude to her.<br><br>An interview was conducted with SSD (Social Services Director) 2 on 9/13/23 at 2:03 p.m. She indicated the CNA that Resident 37 was referencing was CNA 26. She found this out last week after speaking to Resident 37 and UM (Unit Manager) 27. UM 27 informed SSD 2 that CNA 26 was moved to another area of the facility. UM 27 | | practice. Interviewable residents will be interviewed to identify any current concerns. Identified concerns will be addressed by the proper departments.<br>C) staff were in-serviced on customer service and resident rights with a focus on dignity and respect<br>D) Resident interviews will be conducted weekly to identify any concerns with resident rights. 5 residents will be interviewed weekly x 4 weeks by social services or designated representative, then 3 residents weekly x 4 weeks, then 5 residents monthly x 4 months. Any discrepancies will be immediately corrected, and re-education will be provided. Results of the audit will be brought to QAPI for 6 months or until 100% compliance has been achieved. | |

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| | had already moved CNA 26 to another hall by the time SSD 2 went to speak with UM 27 about Resident 37's concerns with CNA 26. "I was gonna stop [name of UM 27] to talk to her about what [name of Resident 37] told me, but [name of UM 27] stopped me and told me she already took care of it. The CNA was [name of CNA 26] and she moved her."<br><br>An interview was conducted with UM 27 on 9/13/23 at 2:38 p.m. She indicated sometimes residents say they don't want a certain CNA caring for them, but she didn't remember moving CNA 26 last week. If she did move her, she couldn't' remember why.<br><br>The 9/7/23 Social Services Note, written as a late entry by SSD 2, read, "Resident had a negative verbal interaction with a staff member. Staff member was put in a different area. [Name of Resident 37] has had no change in mood, behaviors or psychosocial wellbeing. She is up and about the facility per her norm. So far interventions have been effective. Observation will continue."<br><br>The 9/7/23 Grievance/Complaint form for Resident 37 was provided by SSD 2 on 9/13/23 at 2:10 p.m. It read, "Summary of Interview: Writer met with resident @ 2:40 this date. She stated that CNA was rude to her everytime she cared for resident. She went on to share that this was demonstrated by the CNA being loud and fast. She said the CNA just moves her too fast. She could not give anymore specifics other than she works 2-10 p.m. Does not know CNA's name." The Resolution of Grievance/Complaint section indicated the resolution was "CNA moved to another assignment." | | | |

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| | A telephone interview was attempted with CNA 26 on 9/13/23 at 3:52 p.m., but was unavailable for interview. 2. The clinical record for Resident 54 was reviewed on 9/7/23 at 11:00 a.m. The resident's diagnosis included, but was not limited to, diabetes mellitus.<br><br>A Quarterly MDS (Minimum Data Set) Assessment, completed on 8/15/23, indicated she was cognitively intact.<br><br>An interview was conducted with Resident 54 on 9/7/23 at 11:15 a.m. She indicated all the staff are rude in the facility.<br><br>3. The clinical record for Resident 64 was reviewed on 9/7/23 at 11:00 a.m. The resident's diagnosis included, but was not limited to, diabetes mellitus.<br><br>A Quarterly MDS (Minimum Data Set) Assessment, completed on 6/22/23, indicated he was cognitively intact.<br><br>An interview was conducted with Resident 64 on 9/7/23 at 10:40 a.m. He indicated the staff are on their cell phones all the time. They are argumentative, disrespectful and speak to the residents as if they are stupid. 4. The clinical record for Resident 20 was reviewed on 9/7/23 at 2:57 p.m. The Resident's diagnosis included, but were not limited to, hypertension, anxiety, and depression.<br><br>A Quarterly MDS (Minimum Data Set) Assessment, completed 8/19/23, indicated Resident 20 was cognitively intact and could understand what was being said to her and make herself understood.<br><br>During an interview on 9/07/23 at 2:57 p.m., | | | |

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| | Resident 20 indicated she had a grievance within last month that involved a nurse calling her a name. Resident 20 and the nurse were working through it, but Resident 20 hoped it wouldn't happen again.<br><br>On 9/8/23 at 9:58 a.m., the ED (Executive Director) provided an investigation file for a reportable incident between Resident 20 and LPN 3, dated 8/10/23. The reportable investigation file included a copy of the Incident Report, dated 8/10/23 at 3:01 p.m. which read "...Brief Description of Incident... Resident is reporting a nurse got upset with her in a common area and used profanity around her...Immediate Action Taken... Nurse placed on suspension. MD notified. Investigation initiated...Follow up added 8/11/23... after facility investigation that included staff and resident interviews. Allegation is unsubstantiated. Nurse was in conversation with another employee when she stood up and said she needed to take a break. Resident took offense and became upset. Staff educated on abuse policy and nurse educated on customer service..."<br><br>The investigation file included an interview with Resident 20, dated 8/10/23, which read "Around 12:15 p.m. today I put my light on and at 12:30 an aide came in and told the nurse... that I needed my pain pill. At 1:00 p.m. I went to the nurse's station and asked her when got my last pain pill. She [LPN 4] said she'll take care of it. I [Resident 20] said I want to know when I had my last one and [LPN4] said 4:15 a.m. Then I [Resident 20] said "So I could have had it at 12:00". She [LPN 4] said no I don't want to deal with you [Resident 20] right now go back to your room. I [Resident 20] said no I want to talk about how your [LPN 4] way isn't working for me [Resident 20]. She [LPN 4] kept telling me to go back the room and how she | | | |

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| | [LPN 4]"is tired of people and their pain medicine" The aides were saying she [LPN 4] was just upset with people earlier and their pain meds. I [Resident 20] was still up there and while I [Resident 20] was trying to talk to her she [LPN 4] was getting upset and said "B****", loud enough for everyone to hear it and turned around and walked away..."<br><br>The investigation file included an interview with LPN 3 dated 8/11/23, which read "I [LPN 3] was at the nurses' station having a conversation with one of the aides, because I [LPN 3] was already upset because of another issue with a resident yelling at me [LPN3]. [Resident 20] came up to the desk and I [LPN 3] asked her to give her a minute... I [LPN 3] continued my conversation with the aide and [Resident 20] kept trying to interrupt. I [LPN 3] kept saying I would be there in a minute, and if she [Resident 20] could give a little bit as I [LPN 3] was talking with this aide. Finally I [LPN3] told the aide I [LPN 3] had to get out and take a break. I [LPN3] stood up and walked outside for a minute. I [LPN3] didn't say anything out of the way to any residents. I [LPN 3] came back and got [Resident 20] her pain pill she was requesting."<br><br>During an interview on 9/8/23 at 9:50 a.m., LPN 3 indicated she had cared for Resident 20 on 8/10/23 during the day shift. On 8/10/23, LPN 3 had just been "yelled at" by another resident when Resident 20 approached the desk to speak with LPN 3 about a pain pill. LPN 3 had been made aware of Resident 20's request for a pain pill and gave Resident 20 the pain pill when she approached the medication cart. Resident 20 had stayed at the nurses' station after getting her pain pill and wanted to talk to LPN 20 about the last time the pain pill had been given. LPN 3 had | | | |

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| | asked Resident 20 to go back to her room but Resident 20 had stayed at the nurses' station and continued to "chime in" to a conversation LPN 3 was having with a co-worker. LPN 3 had gotten up and left the nursing station to take a break.<br><br>3.1-3(t) | | | |
| F 0557 SS=D Bldg. 00 | 483.10(e)(2)<br>Respect, Dignity/Right to have Prsnl Property<br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.<br>Based on observation, interview, and record review, the facility failed to maintain a resident's dignity regarding possession of medications provided to him by nursing for 1 of 4 residents reviewed for abuse. (Resident 39)<br><br>Findings include:<br><br>The clinical record for Resident 39 was reviewed on 9/7/23 at 9:50 a.m. His diagnoses included, but were not limited to: vascular dementia, post-traumatic stress disorder, chronic pain syndrome, and anxiety disorder.<br><br>The 8/17/23 Admission MDS (Minimum Data Set) assessment indicated Resident 39 had a BIMS (brief interview for mental status) score of 13, indicating he was cognitively intact.<br><br>An interview and observation was conducted with Resident 39 on 9/7/23 at 9:58 a.m. in the | F 0557 | A) Resident 39 was not harmed by the deficient practice and discharged from the facility per his discharge plan<br>B) All residents have the potential to be affected by the deficient practice. Interviewable residents will be interviewed to identify any current concerns. Any identified concerns will be addressed by the proper departments.<br>C) staff were in-serviced on customer service and resident rights with a focus on dignity and respect.<br>D) Resident interviews will be conducted weekly to identify any concerns with resident rights. 5 residents will be interviewed weekly x 4 weeks by social services or designated | 10/27/2023 |

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| | smoking area of the facility. He appeared upset while patting his stomach with his hands and indicated he felt assaulted by LPN (Licensed Practical Nurse) 5, who was also in the smoking area at this time. He was pointing at LPN 5, who was assisting another resident in the smoking area. He indicated it happened last Saturday, 9/2/23, and he told everyone about it and filed a grievance. At this time, Resident 39 provided a 9/5/23 Grievance/Complaint Form that he had on him.<br><br>The 9/5/23 Grievance/Complaint Form read, "Nurse aggressively searched inside my pockets without permission for medication I did not have."<br><br>On 9/7/23 at 9:56 a.m., an interview was conducted with the ED (Executive Director) who provided a copy of the 9/5/23 Resident Rights In Service Sign in Sheets and curriculum at this time. He indicated Resident 39 did not report this incident as abuse and kept changing his story. Education was provided to staff in regards to not searching a resident without permission. Resident 39 was planning to leave the facility LOA (leave of absence) on that day, but changed his mind after having been provided with his medications for the day, including narcotics. He did not go, so the nurse asked for the medications back, but he refused to give them back.<br><br>An observation and interview was conducted with Resident 39 on 9/7/23 at 12:08 p.m. While rubbing and patting on his stomach, he indicated LPN 5 aggressively searched him. He stated, "She cant grab me," and wanted her arrested. He didn't care if she was searching for pills. She should have called the police and had them search him. It wasn't her job to do that. | | representative, then 3 residents weekly x 4 weeks, then 5 residents monthly x 4 months. Any discrepancies will be immediately corrected, and re-education will be provided. Results of the audit will be brought to QAPI for 6 months or until 100% compliance has been achieved. | |

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| | The 9/2/23, 3:07 a.m. nurse's note read, "Approximately 2:30 am when patient came back inside from smoking,I went into patient room to give pain pill. I stated to the patient that it was hydrocodone and is due at 2am. Patient said no, I asked again did he not want pain pill. He said no, patient then stated that he only takes medicine he can see be popped out. I gave patient a hydroxyzine at 23:00 with no issues or asking for me to pop out medication in front of the patient. Patient stated all his medication was to be done in front of him, I explained I did not know that because I had never had to do that for the patient before. I apologize and stated how I wouldn't be able to do that for this medication because I had already popped it out and told patient I could do it for future medications and would communicate to next shift as well. Patient opened his hand so I assumed after what I stated he would now take pain medication, patient then took the cup and did not take medication said he would hold on to it until morning. I stated to patient that he could not have medication stay in the room that he would have to either take the medication or I would have to waste it. Patient stated no began yelling, I then took the medication cup with the hydrocodone. Patient then hit me in the stomach and stood up. I walked out the room and then alerted the nigh [sic] supervisor of the situation."<br><br>The 9/2/23, 8:11 p.m. behavior note, written by LPN 5, read, "Resident not in pleasant mood this shift and not cooperative with nursing staff. Resident stated at 9am that he would be leaving LOA with his family and would need all his medication for the day. Around 2pm resident was still in facility, at this time writer educated resident that if he was not going LOA that writer would need the medication back and will admin [administer] at HS [noc] d/t [due to] narcotics in | | | |

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| | evening medication. Resident refused and became verbally aggressive and physical aggressive trying to push writer out the way with w/c [wheel chair.] At this time writer found other medication packets in his bookbag on w/c that resident had been saving. Resident is being dishonest saying he is leaving LOA to keep medication for the day. Management updated about occurrence. Will continue with current plan of care."<br><br>An interview was conducted with LPN 5 on 9/11/23 at 10:43 a.m. She indicated she was currently off work, because Resident 39 made an allegation that she inappropriately searched him. Earlier in the day on 9/2/23, Resident 39 informed her that he was going LOA with family. She'd also received information in report from the previous shift's nurse that that he would say he was going LOA, but keeping his medications. She took Resident 39's word for it that day, that he would be going LOA, and gave him his medications around 8:30 a.m. for the day to last through 10:00 p.m. Around 2:00 p.m., she saw that he was still in the facility. When she saw him, she told him he could not keep the medications, if he was not leaving. Resident 39 became upset with her, asking why he had to give the medications back. She educated him that she could administer them, since he was still in the facility and that narcotics were to be kept on the medication cart. She would give the medications back to him, if he went out. Resident 39 "started charging at me with his wheel chair to get out of his pathway." This was occurring in the hallway. Another staff member, CNA (Certified Nursing Assistant) 28, intervened, trying to diffuse the situation. Resident 39 had a fanny pack on his wheel chair and you could see what was inside, because it was opened. When she gave him the medications at 8:30 a.m., they were in a packet and she saw him put the packet in | | | |

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| | the fannypack. She saw the packet, but the medications were not the medications she gave him at 8:30 a.m. that morning. They were from several days prior. She never touched him and she never got the medications back that she gave him that day. She did retrieve 5 packets of medications from the fanny pack, but they were from a previous day, which included 3 Hydrocodone 5/325s and 2 Lyrica. She did not want him to be walking around with narcotics, especially given some of things she'd heard, him not leaving when he said he was, and not giving medications back when asked. Afterwards, staff was inserviced on resident rights, she believed in regards to this and other situations with Resident 39.<br><br>An interview was conducted with CNA 28 on 9/11/23 at 1:42 p.m. She indicated LPN 5 was trying tell Resident 39 that she needed the pills back, because she thought he was going to leave. This occurred after 2:00 p.m., by the back door near the therapy department. Resident 39 was by the door, waiting on his ride. LPN 5 was telling him she needed the medication back. Resident 39 was saying "no, no, no." LPN 5 grabbed plastic bags of pills, 3 or 4 of them, from his wheel chair, opened the packets and said they were not the pills she gave him earlier that day, so she held onto them. Resident 39 was cussing. "He kept saying leave me alone, but she didn't touch him." Eventually his ride came and he left the facility that day.<br><br>An interview was conducted with the ED on 9/12/23 at 10:49 a.m. He indicated the inservicing was done as a result of the searching.<br><br>An interview was conducted with the DON (Director of Nursing) on 9/12/13 at 10:16 a.m. She indicated generally, residents told nursing if they | | | |

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| | would be leaving for the day and when they were coming back. The nurse could look to see what medications they would be taking and send the medication with them. The medications would be given to the resident, unless they had a guardian. The medications should be given to a resident upon leaving. As far as the Resident Extended Leave of Absence with Medications policy, she guessed Resident 39's physician was not notified in advance and no release of responsibility was signed, because it was not an extended leave, 24 hours or greater. She understood the medications were in his possession at the time LPN 5 took them from him. It could have gone the other way and he left the facility, when he said he was going to, and all of this wouldn't even have happened. They administered his medications when he was there and LPN 5 took his word for it that he was leaving the facility when he said he was going to leave. Sure, she received report about him being dishonest and some behaviors, but what was wrong with her taking his word for it and having a clean slate with him.<br><br>The Resident Extended Leave of Absence with Medications policy was provided by the ED on 9/11/23 at 12:24 p.m. It read, "Extended Leave of Absence: For the purpose of this policy, means when a resident leaves the facility for 24 hours or greater with consent from the primary provider, not as a discharge but as a therapeutic leave with the full intention of returning to the facility....Due to insurance regulations that limit the number of prescriptions written for a medication during specific time frames, residents will need to take their medications with them...The physician/provider will be notified in advance and will determine which medications and how many, including controlled substances will be permitted to be given to the resident for home visits....The | | | |

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| | resident/representative will sign a Release of Responsibility form for leave of absence with medications."<br><br>3.1-9(a) | | | |
| F 0600<br>SS=D<br>Bldg. 00 | 483.12(a)(1)<br>Free from Abuse and Neglect<br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br><br>Based on interviews and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident for 1 of 4 residents reviewed for abuse (Residents 119).<br><br>Findings include:<br><br>1 a. The clinical record for Resident 119 was reviewed on 9/12/23 at 10:29 a.m. The Resident's diagnosis included, but were not limited to, intermittent explosive disorder and depression.<br><br>A Quarterly MDS (Minimum Data Set) Assessment, completed 6/26/23, indicated he was cognitively intact. | F 0600 | A) Resident 119 was not harmed by the deficient practice beyond a minor bloody nose and remains at his psychosocial baseline.<br>B) All residents have the potential to be affected. Interviewable residents will be interviewed to identify if they have any current concerns with peers. Any identified concerns will be addressed by the IDT team.<br>C) Residents 109 and 119 were educated on proper interactions with peers. Staff continue with ongoing abuse education including identifying conflict and conflict | 10/27/2023 |

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| | A care plan, initiated 5/30/23, indicated Resident 119 had a behavior problem of losing his temper easily, banging his arm on the desk, alcohol use, and verbal aggression. The goal was for him to have fewer episodes of behaviors. The interventions, initiated 5/30/23, were to administer his medication as ordered, approach and speak in a calm manor, behavioral health consults as needed, communicate with resident and resident representative regarding behaviors and treatment, encourage him to express his feelings, intervene as necessary to protect the rights and safety of others, monitor behavioral episodes and attempt to determine underlying causes, notify medical provider of increased episodes of behaviors, and praise him for any indication of progress in behaviors.<br><br>1 b. The clinical record for Resident 109 was reviewed on 9/12/23 at 10:40 a.m. The Resident's diagnosis included, but were not limited to, anxiety disorder and intermittent explosive disorder.<br><br>A Quarterly MDS Assessment, completed 6/30/23, indicated he was cognitively intact.<br><br>Resident 109's clinical record contained a nursing progress note, dated 6/29/2023 at 8:12 p.m., which indicated Resident 109 had gotten into a verbal disagreement with a male peer (Resident 119) while in the courtyard, Resident 109 had hit male peer (Resident 119) with an open hand, making contact with his nose. Both residents were immediately separated. An investigation was initiated. The physician and the Executive Director were notified. The psychiatric Nurse Practitioner was in the facility and assessed both | | resolution.<br>D) Resident interviews will be conducted weekly to identify any concerns with peers. 5 residents will be interviewed weekly x 4 weeks by social services or designated representative, then 3 residents weekly x 4 weeks, then 5 residents monthly x 4 months. Any discrepancies will be immediately corrected, and re-education will be provided. Results of the audit will be brought to QAPI for 6 months or until 100% compliance has been achieved. | |

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| | residents. Resident 109 was educated on proper interactions with peers.<br><br>On 9/12/23 at 11:55 a.m., the ED (Executive Director) provided the investigation file for the incident between Resident 109 and Resident 119. The investigation file included the Reportable Incident which read "... Brief Description of Incident...Resident [119] and Resident [109] got into a verbal disagreement in the courtyard. Resident [109] then hit Resident [119] with an open hand making contact with his nose.... Follow up added 7/6/23 Investigation completed. No further issues at this time. Residents both remain at psychosocial baseline with no new concerns. Both residents educated on proper interaction with others. Care plan updated for both residents. Psych [sic] provider has seen both residents. Staff educated on resident-to-resident interactions..."<br><br>During an interview on 9/12/23 at 1:01 p.m., SSD (Social Service Director) 2 indicated that Resident 119 and Resident 109 had an altercation in the courtyard on 6/29/23. The altercation had started because Resident 109 had been speaking inappropriately about a female resident of the facility and Resident 109 had taken offense at what Resident 109 was saying about the female resident. Resident 109 had hit Resident 119. The female resident in question had not been present when the incident occurred.<br><br>On 9/6/23 at 12:59 p.m., the ED provided the current Abuse and Neglect and Misappropriation of Property policy which read "...Definitions...Physical Abuse: In Indiana, is defined as a willful act against a resident by another resident, staff, or other individuals. Examples: hitting, beating, slapping, punching, shoving, spitting, striking with an object...Policy: | | | |

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| | It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. It is the intent of the facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property...<br><br>3.1-27(a)(1) | | | |
| F 0622<br>SS=D<br>Bldg. 00 | 483.15(c)(1)(i)(ii)(2)(i)-(iii)<br>Transfer and Discharge Requirements<br>§483.15(c) Transfer and discharge-<br>§483.15(c)(1) Facility requirements-<br>(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-<br>(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;<br>(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;<br>(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;<br>(D) The health of individuals in the facility would otherwise be endangered;<br>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, | | | |

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| | denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or<br>(F) The facility ceases to operate.<br>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.<br><br>§483.15(c)(2) Documentation.<br>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.<br>(i) Documentation in the resident's medical record must include:<br>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.<br>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).<br>(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-<br>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) | | | |

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| | (1) (A) or (B) of this section; and<br>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.<br>(iii) Information provided to the receiving provider must include a minimum of the following:<br>(A) Contact information of the practitioner responsible for the care of the resident.<br>(B) Resident representative information including contact information<br>(C) Advance Directive information<br>(D) All special instructions or precautions for ongoing care, as appropriate.<br>(E) Comprehensive care plan goals;<br>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.<br><br>Based on interview and record review, the facility failed to ensure a resident's facility-initiated discharge information was conveyed to the resident/resident representative and the discharge summary contained a complete recapitualization of the resident's stay, a final summary of the resident's status, the efforts to assist the resident in locating a continuing care provider, and the reconciliation of medications for 1 of 3 residents reviewed for discharge. (Resident 348)<br><br>Findings include:<br><br>The clinical record for Resident 348 was reviewed on 9/13/23 at 10:21 a.m. Resident 348's diagnoses included, but not limited to, metabolic encephalopathy (an issue in the brain caused by a chemical imbalance related to an illness or organs | F 0622 | A) Resident 348 remains discharged from the facility and was not harmed by the deficient practice.<br>B) All discharged residents have the potential to be affected. An audit will be performed on residents discharged in the last 14 days to ensure discharge recapitulations and medication dispositions were completed.<br>C) Licensed Nurses were educated on medication disposition at discharge process and MD was notified of need for discharge recapitulation on discharged residents<br>D) Facility will complete an audit of 5 resident discharges per week | 10/27/2023 |

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| | that are not working as well as they should) and alcoholic cirrhosis of the liver (liver damage).<br><br>An admission MDS (minimum data set) dated 7/22/23 indicated, Resident 348 was cognitively intact and could make medical decisions himself.<br><br>A letter from Resident 348's insurance company dated 7/25/23 indicated, Resident 348's rehabilitation needs could be met at a lower level of care and for that reason any further skilled nursing facility (SNF) care was not medically necessary.<br><br>A Service Note dated 7/27/2023 at 10:28 a.m. indicated, Resident 348's denial of coverage letter was received and indicated, his the last covered date was 7/24/23 and the IDT (Interdisciplinary team) was made aware.<br><br>An interview with SSD (Social Services) 1 conducted on 9/14/23 at 9:36 a.m. indicated, the facility received a "cut" letter from Resident 348's insurance company near the end of July 2023. SSD 1 stated, when she called the resident's mother to inform her of his discharge and to confirm the address he had listed as his last place of residence, Resident 348's mother said to her that he had not lived at that address in a while and later confirmed he was homeless and had been living at a homeless shelter. SSD 1 had spoke to Resident 348 after the phone call and he admitted he had been living at the homeless shelter until his mom was able to save up money for a bus ticket out of state. SSD 1 indicated, Resident 348 had agreed to go back to the homeless shelter until his mother could send the money.<br><br>Resident 348's clinical record did not indicate he had agreed to go to a homeless shelter nor the | | for 4 weeks then, 3 resident discharges per week for 8 weeks then, 1 resident discharge per week for 12 weeks to ensure medication disposition has been completed. Any discrepancies will be immediately corrected, and re-education will be provided. MD will provide discharge recapitulation for discharged residents' medical records. This will be an ongoing facility practice. Results of the audit will be brought to QAPI for 6 months or until 100% compliance has been achieved. | |

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| | method of transportation to the homeless shelter. Additionally, the clinical record failed to indicate the following information was conveyed to the resident/resident representative as close as possible to the time of discharge:<br>- The contact information of the practitioner who was responsible for his care.<br>- Special instructions and/or precautions for ongoing care such as, sign/symptoms of infection related to a wound on his spine that required dressing changes three times per week and when to seek medical attention.<br>- Information necessary to meet his needs such as, medications (including when last received).<br><br>Resident 348's discharge summary was provided by Infection Preventionist (IP) on 9/14/23 at 11:12 a.m. The discharge summary was completed on 7/27/23. The discharge summary failed to contain:<br>- A completed recapitulation (a concise summary of the resident's stay and course of treatment in the facility) that included: course of illness/treatment.<br>- A final summary of the resident's status which must include: customary routine, cognitive patterns, communication, vision, mood/behavior patterns, psychosocial wellbeing, continence, disease diagnosis and health conditions, dental and nutritional status, skin condition, activity pursuit, medications, special treatments, and procedures.<br>Resident 348's care plan dated 7/15/23 indicated, Resident 348 wished to return to the community upon discharge and interventions included, but no limited to, make arrangements with required community resources to support independence post-discharge.<br><br>A late entry nursing note dated 7/28/2023 at 5:59 p.m. indicated Resident 348 was discharged from | | | |

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| | the facility that day with all medications, discharge summary, and medication list. A disposition of the medications (other than the Oxycodone) was not included in the clinical record.<br><br>A Social Services note dated 8/1/2023 at 10:32 a.m. indicated, Resident 348 discharged from the facility on 7/28/23 to a homeless shelter.<br><br>A Discharge Planning policy received on 9/14/23 at 11:12 a.m. from IP indicated, "...to ensure that the facility has a discharge planning process in place which addresses each resident's discharge goals and needs..."<br><br>3.1-12(a)<br>3.1-25(p)<br>3.1-25(s) | | | |
| F 0623 SS=D Bldg. 00 | 483.15(c)(3)-(6)(8)<br>Notice Requirements Before Transfer/Discharge<br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section. | | | |

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| | 155334 | A. BUILDING 00<br>B. WING | 09/14/2023 |

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| WILDWOOD HEALTHCARE CENTER | 7301 E 16TH ST<br>INDIANAPOLIS, IN 46219 |

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| | §483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; | | | |

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| | (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § | | | |

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| | 483.70(l).<br>Based on interview and record review, the facility failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman at the same time the notice was provided to the resident and/or resident representative for 1 of 3 residents reviewed for discharge. (Resident 348)<br><br>Findings include:<br><br>The clinical record for Resident 348 was reviewed on 9/13/23 at 10:21 a.m. Resident 348's diagnoses included, but not limited to, metabolic encephalopathy (an issue in the brain caused by a chemical imbalance related to an illness or organs that are not working as well as they should) and alcoholic cirrhosis of the liver (liver damage).<br><br>An admission MDS (minimum data set) dated 7/22/23 indicated, Resident 348 was cognitively intact and could make medical decisions themselves.<br><br>A letter from Resident 348's insurance company dated 7/25/23 indicated, Resident 348's rehabilitation needs could be met at a lower level of care and for that reason any further skilled nursing facility (SNF) care was not medically necessary.<br><br>A Service Note dated 7/27/2023 at 10:28 a.m. indicated, Resident 348's denial of coverage letter was received and indicated, his the last covered date was 7/24/23 and the IDT (Interdisciplinary team) was made aware.<br><br>An interview with SSD (Social Services) 1 conducted on 9/14/23 at 9:36 a.m. indicated, the facility received a "cut" letter from Resident 348's | F 0623 | A) Resident remains discharged from the facility and was not harmed by the deficient practice.<br>B) All discharged residents have the potential to be affected. An audit will be conducted on residents discharged in the last 14 days to ensure notification to ombudsman was completed. Any discharges that are identified to not have ombudsman notification will be sent to ombudsman.<br>C) Social services and business office manager were educated on notice requirements before transfer/discharge with an emphasis on ombudsman notification.<br>D) Facility will complete an audit of 5 resident discharges per week for 4 weeks then, 3 resident discharges per week for 8 weeks then, 1 resident discharge per week for 12 weeks to ensure ombudsman notification. Any discrepancies will be immediately corrected, and re-education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. | 10/27/2023 |

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| | insurance company near the end of July 2023. SSD 1 stated, when she called the resident's mother to inform her of his discharge and to confirm the address he had listed as his last place of residence, Resident 348's mother said to her that he had not lived at that address in a while and later confirmed he was homeless and had been living at a homeless shelter. SSD 1 had spoke to Resident 348 after the phone call and he admitted he had been living at the homeless shelter until his mom was able to save up money for a bus ticket out of state. SSD 1 indicated, Resident 348 had agreed to go back to the homeless shelter until his mother could send the money. When asked if the Long-Term Ombudsman's office had been sent a copy of Resident 348's discharge notice, she indicated, there was no indication a notice had been sent and it "probably" should have been sent.<br><br>Resident 348's care plan dated 7/15/23 indicated, Resident 348 wished to return to the community upon discharge and interventions included, but no limited to, make arrangements with required community resources to support independence post-discharge.<br><br>A late entry nursing note dated 7/28/2023 at 5:59 p.m. indicated Resident 348 was discharged from the facility that day with all medications, discharge summary, and medication list.<br><br>A Social Services note dated 8/1/2023 at 10:32 a.m. indicated, Resident 348 discharged from the facility on 7/28/23 to a homeless shelter.<br><br>A Discharge Planning policy was received on 9/14/23 at 11:12 a.m. from IP (Infection Preventionist). The policy effective 7/17/2020 indicated, "The requirement intends to ensure that | | | |

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| | the facility has a discharge planning process in place which addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies...and involves the resident and if applicable, the resident representative and the interdisciplinary team in developing the discharge plan."<br><br>3.1-12(a)(6)(A)<br>3.1-12(a)(9)(G) | | | |
| F 0644<br>SS=D<br>Bldg. 00 | 483.20(e)(1)(2)<br>Coordination of PASARR and Assessments<br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>Based on interview and record review, the facility failed to accurately complete a Preadmission Screening and Resident Review (PASRR) level I for 2 of 2 residents PASRR reviewed. (Resident 64 and Resident 82)<br><br>Findings include: | F 0644 | A) Residents 64 and 82 were not harmed by the deficient practice.<br>B) All residents have the potential to be affected. An audit will be conducted on all Preadmission Screenings and Resident Review (PASSAR) completed in the last | 10/27/2023 |

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| | 1. The clinical record for Resident 64 was reviewed on 9/13/23 at 8:50 a.m. The resident's diagnoses included, but were not limited to, post-traumatic stress disorder, major depressive disorder and cocaine abuse. The resident's admission date was 11/24/21.<br><br>A PASRR level I screening dated 12/8/21 indicated the resident did not have a substance abuse disorder.<br><br>An interview was conducted with Social Services Director 1 on 9/13/23 at 1:39 p.m. She indicated the resident's cocaine diagnosis in error was not included on the level 1 screening that was completed on 12/8/21.<br><br>2. The clinical record for Resident 82 was reviewed on 9/13/23 at 2:11 p.m. The resident's diagnoses included, but were not limited to, crohn's disease and schizophrenia. The resident's admission date was 6/30/20.<br><br>A PASRR level I screening dated 11/3/20 indicated the resident did not have a mental health diagnosis. The screen outcome indicated "The level I screen indicates that a PASRR disability is not present because of the following reason: There is no evidence of a PASRR condition of an intellectual/development disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted."<br><br>The resident's clinical record indicated the resident was diagnosed with schizophrenia on 4/16/21. The medical record did not include a new level I screening had been completed due to the resident' diagnosis of schizophrenia. | | 14 days to validate accuracy.<br>C) Social services were educated on accurate completion of Preadmission Screening and Resident Review (PASRR) level 1.<br>D) Facility will complete an audit of 5 residents with related conditions per week for 4 weeks then, 3 residents with related conditions per week for 8 weeks then, 1 resident with related conditions per week for 12 weeks to ensure status change assessments are being completed and accurate completion of Preadmission Screenings and Resident Review. Any discrepancies will be immediately corrected, and re-education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. Any discrepancies will be corrected immediately. | |

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| | An interview was conducted with the Social Services Director 1 on 9/13/23 at 1:39 p.m. She indicated a new Level I screening should have been conducted after the resident was diagnosed with schizophrenia. It was missed. | | | |
| F 0656 SS=D Bldg. 00 | 483.21(b)(1)(3)<br>Develop/Implement Comprehensive Care Plan<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)- | | | |

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| | (A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>Based on observation, interview, and record review, the facility failed to ensure a resident had care plans to address her dementia, edema, and hypertension for 1 of 33 residents reviewed for care plan creation. (Resident 41)<br><br>Findings include:<br><br>The clinical record for Resident 41 was reviewed on 9/8/23 at 2:43 p.m. Her diagnoses included, but were not limited to: vascular dementia, hypertension, heart failure, and edema.<br><br>The Diagnosis Information section on Resident 41's Admission Record tab from the electronic health record indicated diagnoses of acute pulmonary edema, vascular dementia, and hypertension, all with onset dates of 1/23/23.<br><br>The physician's orders indicated she was to receive one 5 mg tablet of Amlodipine every morning for hypertension, starting 6/1/23; one 25 mg tablet of Carvedilol every morning and at | F 0656 | A) Resident 41 was not harmed by the deficient practice and care plans were added for dementia, edema, and hypertension diagnosis<br>B) All residents have the potential to be affected. An audit will be completed to ensure care plan completion of diagnosis.<br>C) MDS, social services, and nurse managers were educated on facility policy “Plan of Care overview” with an emphasis on care plan completion including residents’ diagnosis.<br>D) Facility will complete an audit of 5 resident care plans per week for 4 weeks then, 3 resident care plans per week for 8 weeks then, 1 resident care plan per week for 12 weeks to ensure residents diagnosis have been care planned. Any discrepancies will be | 10/27/2023 |

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| | bedtime for hypertension, starting 5/31/23; and one 20 mg tablet of Furosemide in the morning for edema, starting 1/24/23.<br><br>Review of Resident 41's care plans indicated no care plans to address her dementia, hypertension, or edema.<br><br>An interview was conducted with the MDSC (Minimum Data Set Coordinator) on 9/14/23 at 1:36 p.m. She indicated the MDS department created care plans, usually based on the MDS assessments. As due diligence, they added to care plans on a quarterly basis, but worked on care plans as a team. The MDSC reviewed Resident 41's care plans and indicated she did not see care plans to address Resident 41's dementia, hypertension, or edema. Some of the interventions necessary to address Resident 41's edema would be to monitor her weight, and to observe for shortness of breath and swelling. As far as her dementia, social services would be responsible for that care plan.<br><br>An interview was conducted with SSD (Social Services Director) 1 on 9/14/23 at 1:49 p.m. She indicated nursing or the MDS department would generally be responsible for creating a dementia care plan. She reviewed Resident 41's care plans and indicated she didn't have one, but was creating one right now. Interventions to address her dementia would be to administer her medication as ordered; to communicate with family regarding her capabilities and needs; discuss concerns about confusion/disease process; involve Resident 41 in daily decision making and activities; and to keep her routine as constant as possible.<br><br>The Plan of Care Overview policy was provided | | immediately corrected, and re-education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. | |

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| | by the AIT (Administrator in Training) on 9/14/23 at 3:29 p.m. It read, "The facility will: ...Review care plans quarterly and/or with significant changes in care....Nurses are expected to participate in the resident plan of care for reviewing and revising the care plan of residents they provide care for as the resident's condition warrants....Care Plan documents...Care plan documents are resident specific/resident focused and reflect resident/representative opportunities for participation and preferences."<br><br>3.1-35(a) | | | |
| F 0657<br>SS=D<br>Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's | | | |

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| | needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br><br>Based on interview and record review, the facility failed to ensure a resident's care plan was reviewed and revised quarterly and/or with significant changes in care by the interdisciplinary team and to the extent practicable, the participation of the resident and/or resident's representative for 1 of 1 resident reviewed for care planning (Resident 14).<br><br>Findings include:<br><br>The clinical record for Resident 14 was reviewed on 9/11/23 at 3:18 a.m. The Resident's diagnosis included, but were not limited to, diabetes.<br><br>A Quarterly MDS (Minimum Data Set) Assessment, completed 8/16/23, indicated she was cognitively intact.<br><br>During an interview on 9/6/23 at 3:04 p.m., Resident 14 indicated she had not attended an interdisciplinary care plan meeting for awhile.<br><br>The clinical record did not contain any interdisciplinary care plan notes since 9/28/22.<br><br>During an interview on 9/11/23 at 3:47 p.m., SSD (Social Services) 2 indicated, if a care plan meeting had been scheduled and/or conducted, the care plan meeting notes would be in the EHR (Electronic Health Record) under the "progress notes" section. She further indicated, if there weren't any care plan meeting notes in the resident's EHR then it hadn't been done. | F 0657 | A) Resident 14 was not harmed by the deficient practice and had a quarterly care plan scheduled.<br>B) All residents have the potential to be affected. An audit will be conducted on all residents to identify the date of the last care plan and care plan meetings will be scheduled.<br>C) Social services were educated on facility policy “Plan of Care Overview” with an emphasis on completing quarterly care plan meetings timely.<br>D) Facility will complete an audit of 5 residents per week for 4 weeks then, 3 residents per week for 8 weeks then, 1 resident per week for 12 weeks to ensure quarterly care plan has been held per MDS quarterly schedule. Any discrepancies will be immediately corrected, and re-education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. | 10/27/2023 |

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| | On 9/12/23 at 8:30 a.m., the Director of Nursing provided the Plan of Care Overview policy, it indicated, "It is the policy of this facility to provide resident centered care...to support the inclusion of the resident or resident representative in all aspects of person centered care planning...The facility will:..Review care plans quarterly and/or with significant changes in care...Attendees will sign and date care plan meeting agenda/documents."<br><br>3.1-35(d)(2)(B) | | | |
| F 0688 SS=D Bldg. 00 | 483.25(c)(1)-(3)<br>Increase/Prevent Decrease in ROM/Mobility<br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>Based on observation, interview and record review, the facility failed to ensure an orthotic (splint) hand device was provided for 1 of 1 residents reviewed for range of motion. (Resident | F 0688 | A) Resident 47 was not harmed by the deficient practice. Resident 47 was screened by Occupational Therapy and added to therapy | 10/27/2023 |

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| | 47)<br><br>Findings include:<br><br>The clinical record for Resident 47 was reviewed on 9/6/23 at 2:40 p.m. The resident's diagnosis included, but was not limited to, stroke.<br><br>Observations were made of Resident 47 on 9/6/23 at 2:50 a.m. and 9/13/23 at 12:03 p.m. The resident's left hand was not observed with a orthotic device.<br><br>An observation was made of Resident 47 with License Practical Nurse (LPN) 10 on 9/14/23 at 1:30 p.m. The resident was observed with no orthotic device on her left hand.<br><br>An interview was conducted with LPN 50 on 9/14/23 at 1:35 p.m. She indicated the resident's clinical record did not indicate the resident had an order to wear an orthotic device. She does not receive restorative services to provide range of motion exercises.<br><br>An Occupational Therapy Discharge Summary for Resident 47 dated 7/25/22 indicated the resident was to wear an orthotic device daily for contracture management.<br><br>A therapy screen conducted on 11/28/22 indicated Resident 47's contracture management was to continue.<br><br>An interview was conducted with the Minimum Data Set (MDS) Coordinator on 9/14/23 at 2:58 p.m. She indicated the therapy department was to conducted evaluations every quarter. Resident 47's Occupational discharge summary indicated the resident was to wear an orthotic device for contracture management. The nursing department | | caseload.<br>B) All residents requiring splints have the potential to be affected. An audit will be conducted to ensure all residents have been screened within the last quarter and if splints are recommended the resident has an order and a program in place. Any residents identified as not having been screened in the last quarter will be added to the quarterly screening schedule.<br>C) Therapy manager and staff were educated on quarterly therapy screens with an emphasis on ensuring orthotic devices/contracture management recommendations are communicated to nursing department.<br>D) Facility will complete an audit of 5 residents per week for 4 weeks then, 3 residents per week for 8 weeks then, 1 resident per week for 12 weeks to ensure quarterly screenings have been completed by therapy and any recommendations for orthotic devices/contracture management have been relayed to the nursing department. Any discrepancies will be immediately corrected, and re-education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. | |

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| | had not received the referral. The therapy department will be reevaluating resident's contracture management.<br><br>3.1-42(a)(2) | | | |
| F 0740<br>SS=E<br>Bldg. 00 | 483.40<br>Behavioral Health Services<br>§483.40 Behavioral health services.<br>Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.<br><br>Based on interview and record review, the facility failed to develop and implement a plan of care for a resident with intermittent explosive disorder after a physical altercation with another resident; update a plan of care with new interventions for a resident with intermittent explosive disorder after an incident of verbal aggression against another resident; develop and implement a plan of care, upon admission, for a resident with known active substance use disorder; update and revise a resident's plan of care with individualized new interventions to address his behaviors; and provided a resident his leave of absence medication, including narcotics, in advance, instead of upon leaving the facility, for a resident with a history of physically aggressive behavior related to his narcotic medication for 1 of 4 residents reviewed for abuse and 4 of 5 residents reviewed for behaviors. (Residents 39, 99, 109, | F 0740 | A) Residents 39, 99, 109, 119, and 310 were not harmed by the deficient practice. Residents 109, 119, and 99 care plans and behavior monitoring /interventions were reviewed and updated as appropriate. Residents 310 and 39 remain discharged from the facility.<br>B) All residents have the potential to be affected. An audit will be conducted on the last 14 days of progress notes to identify any behaviors and ensure that care plans and behavior monitoring/interventions have been updated as needed.<br>C) Social services and nurse managers were educated on behavior monitoring/intervention | 10/27/2023 |

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| | 119, and 310).<br><br>Findings include:<br><br>1. The clinical record for Resident 109 was reviewed on 9/12/23 at 10:40 a.m. The Resident's diagnosis included, but were not limited to, anxiety disorder, intermittent explosive disorder and psychoactive substance abuse.<br><br>A Quarterly MDS Assessment, completed 6/30/23, indicated he was cognitively intact.<br><br>Resident 109's clinical record contained a nursing progress note, dated 6/29/2023 at 8:12 p.m., which indicated Resident 109 had gotten into a verbal disagreement with a male peer (Resident 119) while in the courtyard, Resident 109 had hit male peer (Resident 119) with an open hand, making contact with his nose. Both residents were immediately separated. An investigation was initiated. The physician and the Executive Director were notified. The psychiatric Nurse Practitioner was in the facility and assessed both residents. Resident 109 was educated on proper interactions with peers.<br><br>An Initial Psych Med Management Visit note, dated 6/29/23, indicated Resident 109 had been seen due to hitting a peer (Resident 119) in the nose while outside in the smoking area. His past psychiatric history includes being in prison many times and being in solitary confinement while in prison. His behavior during the exam was calm and seemed remorseful. Resident 109 indicated his temper can go from "0 to 60" in a minute. He has a history of violence but had done well here. The plan was to add diagnosis of intermittent explosive disorder and begin Depakote (mood stabilizer) 500mg daily at bedtime. | | updates and behavioral care plan updates.<br>D) Facility will complete an audit of 5 residents per week for 4 weeks then, 3 residents per week for 8 weeks then, 1 resident per week for 12 weeks to ensure that any residents with behaviors have behavior monitoring and interventions and behavior care plans and that they are updated as needed. Any discrepancies will be immediately corrected, and re-education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. | |

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A Follow Up Psych Med Management Visit note, dated 7/13/23, indicated the visit had been to follow up on mood and anger. Resident 109 indicated he had a long history. He admitted that anything could send him into anger. The plan was to continue Depakote use and to follow up the next month.

During an interview on 9/12/23 at 1:33 p.m., LPN (Licensed Practical Nurse) 4 indicated Resident 109 had displayed behaviors such as verbal aggression with the staff. Resident 109 would "flip out" over anything. When Resident 109 was first admitted to the facility the behaviors had been worse. When Resident 109 had behaviors, the staff would normally just "leave him alone".

During an interview on 9/14/23 at 10:14 a.m., SSD (Social Services Director) 2 indicated she had not been aware of Resident 109 explosive behaviors prior to the incident between Resident 109 and Resident 119. Resident 109 had not been previously offered services the Psychiatric Nurse Practitioner. There had not been a care plan developed for Resident 109's explosive behaviors and new diagnosis of intermittent explosive disorder. A behavioral plan of care should have been developed.

2. The clinical record for Resident 119 was reviewed on 9/12/23 at 10:29 a.m. The Resident's diagnosis included, but were not limited to, intermittent explosive disorder, depression, opioid dependence, and alcohol dependence, in remission.

A Quarterly MDS (Minimum Data Set) Assessment, completed 6/26/23, indicated he was

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| | cognitively intact.<br><br>A care plan initiated 4/3/23 indicated Resident 119 had a history of substance use disorder related to history of drug and alcohol abuse. Alcoholics Anonymous and Narcotics Anonymous had been made available. The goal was for him to articulate the risks of continued alcohol use. The interventions included, but were not limited to, administer medications as ordered, initiated 4/3/23, educate resident and/or resident representative on following the prescribed treatment regime and leave of absence policy, initiated 4/3/23, evaluate him for symptoms such as nodding off while in mid conversation, incoherent speech/ slurred speech, erratic behavior, rambling, sweaty, unruly appearance and report to medical provider, initiated 4/3/23, offer emotional support regarding choices with treatment plan, initiated 4/3/23.<br><br>A care plan, initiated 5/30/23, indicated Resident 119 had a behavior problem of losing his temper easily, banging his arm on the desk, alcohol use, and verbal aggression. The goal was for him to have fewer episodes of behaviors. The interventions, initiated 5/30/23, were to administer his medication as ordered, approach and speak in a calm manor, behavioral health consults as needed, communicate with resident and resident representative regarding behaviors and treatment, encourage him to express his feelings, intervene as necessary to protect the rights and safety of others, monitor behavioral episodes and attempt to determine underlying causes, notify medical provider of increased episodes of behaviors, and praise him for any indication of progress in behaviors.<br><br>A Follow up Psych Med Management Visit note, dated 6/2/23, indicated staff documented that | | | |

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| | Resident 109 had been on a leave of absence and acted intoxicated with slurred speech and that his narcotic medications had been held after notifying the physician. Resident 119 had been moved after issues with his roommate. Resident 119 had displayed excessive outburst of anger and cursing with peers and staff.<br><br>A Follow up Psych Med Management Visit note, 6/29/23, indicated Resident 119 and a peer (Resident 109) had a verbal episode and Resident 119 had ended up with a nosebleed. Resident 119 had long history of substance use disorder, temper issues with staff, roommates and peers. Resident 119 had polysubstance abuse and had been using here off and on. It was hard to tell if he was intoxicated or coming off an agent. Resident 119 was encouraged to "take the high road" if arguments start and to leave the area. The plan was to encourage Resident 119 to return to his room when he felt angry. Resident 119 loved music.<br><br>A nursing progress note dated 8/26/23 at 11:04 p.m. by LPN 5 read "...Resident [119] returned to facility very lethargic but easily aroused. Resident [119] had no shirt or shoes on and a small skin tear to the bottom of left foot. Moderated blood noted. Left food cleansed and secured with bandage. Resident resting in bed at this time with call light in reach. Will continue with current plan of care..."<br><br>During an interview on 9/12/23 at 10:39 a.m., LPN 5 indicated she had cared for Resident 119 on the evening shift 8/29/23. LPN 5 was not sure if Resident 119 was intoxicated when he returned from leave of absence that night. LPN 5 had wondered if Resident 119 and his brother may have gotten into a "tussle", it was hard to tell. | | | |

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| | LPN 5did not recall if she called the physician or if the physician had been informed the next day.<br><br>During an interview on 9/12/23 at 1:35 p.m., LPN 4 indicated the Resident 119 would go on leave of absence and come back intoxicated. Resident 119 would also go to the smoking area and upon returning would have increased behaviors such as yelling. Resident 119 had displayed behaviors such as hitting the nurses' station counter with such force that Resident 119 sustained a broken arm. LPN 4 had informed management of the behaviors and was told to continue to educate.<br><br>During an interview on 9/14/23 at 10:14 a.m., SSD (Social Services Director) 2 indicated Resident 119's behavior plan of care should have been updated after the incident with Resident 109 in the courtyard.<br><br>3. The clinical record for Resident 310 was reviewed on 9/12/23 at 1:45 p.m. The Resident's diagnosis included, but were not limited to, psychoactive substance abuse, opioid dependence, fractured right wrist and hand, fractured left femur, and accidental discharge from unspecified firearms or gun. He was admitted to the facility on 7/31/23 and discharged from the facility on 8/6/23.<br><br>Resident 310's clinical record contained a History and Physical Note from the admitting acute care hospital, dated 7/19/23, which read "...Patient is a 25 yo[sic] male arrived to...ED[sic] after suffering multiple GSWs[sic] at a house known for drug consumption...Per EMS[sic] and patient he is positive for recent Meth[sic] use tonight...Takes Klonopin and Roxicodone recreationally...Polysubstance abuse- daily meth | | | |

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| | [sic] use- klonopin and roxi[sic] recreationally-anticipated patient will be very difficult wean without agitation issues..."<br><br>The clinical record contained the acute hospital's Discharge Information, dated 7/31/23, which read "...Patient is currently homeless as he was living with his grandfather, but under house arrest...Meth [sic] daily since 2020..."<br><br>The clinical record contained the On-Boarding Clinical Evaluation which indicated Resident 310 was admitted to the acute care hospital on 7/19/23. The reasons for skilled nursing facility admission were wound care, IV (Intravenous) antibiotic therapy, ostomy care and physical and occupational therapy. The clinical synopsis of his hospital admission included his polysubstance abuse of daily meth use as well as klonopin and roxi (narcotic pain medication) recreationally, and marijuana daily.<br><br>The Admission Initial Evaluation, dated 7/31/23 at 11:07 p.m., indicated was alert and oriented to person, place, and time. He had a history of substance use disorder.<br><br>The Baseline Care Plan, dated 7/31/23, indicated no behavior concerns.<br><br>A physician's order, dated 8/1/23, indicated Resident 310 was to receive Naloxone (opiate antagonist) liquid 4mg(milligram) per 0.1 ml (milliliter) in nostril as needed for opioid use upon signs of opioid overdose. May repeat in alternating nostrils every 2 to 3 minutes until resident responds or additional medical assistance arrives.<br><br>An Initial Psych Med Management Visit note, | | | |

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| | dated 8/3/23, indicated Resident 310 was seen as a new resident. Resident 310 had not been cooperative with the interview and had become defensive and hostile during the exam. Resident 310 had denied having a drug problem.<br><br>A nursing progress note, dated 8/3/23 at 5:37 p.m., read "...patient was unresponsive in the courtyard [sic] was administered Narcan [Naloxone] times 2. vitals signs Stable. Patient refused a room search. Patient aroused became combative with staff pulled of his colostomy and threw it on the floor. Refusing to go the hospital. Patient is his own POA [sic] and did not want staff to notify anyone on his contact list. MD notified new order to hold all narcotics for 24 hours."<br><br>A social service progress note, dated 8/4/23 at 3:31 p.m., indicated the facility Drug and Alcohol Policy had been reviewed with Resident 310, who denied that he has "used" since his admission to the facility.<br><br>The clinical record did not contain a plan of care for Resident 310's substance use disorder.<br><br>During an interview on 9/13/23 at 9:45 a.m., LPN 6 indicated that if a resident had a history of SUD (substance use disorder), it was normally communicated through the hospital discharge paperwork. The staff were not normally informed of how recently the resident with a history of SUD had last used the substance. LPN 6 was unaware if any extra monitoring or interventions had been implemented for Resident 310 after he was given the Naloxone at the facility.<br><br>During an interview on 9/13/23 at 10:20 a.m., LPN 4 indicated she had been the nurse assigned to Resident 310's care on 8/3/23 during the day shift. | | | |

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| | LPN 4 had been made aware that Resident 310 had a history of SUD but was not aware that he was actively using methamphetamine prior to his admission to the acute care hospital on 7/19/23.<br><br>During an interview on 9/13/23 at 10:34 a.m., LPN 5 indicated that she had taken report from the acute care hospital when Resident 310 was admitted to the facility on 7/31/23. During the report the acute care hospital had informed her that Resident 310 had a "real bad" drug problem and that when it was time for Resident 310 to discharge from the facility the police department was to be informed due to Resident 310 having active warrants due to the "gunshot incident". LPN 5 had written out a report sheet and verbally informed the oncoming nurse of the report she was given. Due to the report she had received from the acute care hospital, she was not surprised that Narcan (Naloxone) had been administered to Resident 310.<br><br>During an interview on 9/13/23 at 11:15 a.m., the Director of Nursing indicated that she was not involved in the decision making process for potential admission. She had not been made aware of Resident 310's active drug history or of his need to have the police informed of his discharge from the facility prior to his admission on 7/31/23. The nursing staff at the facility had not informed her of the information obtained in report from the acute care hospital about Resident 310 drug use and the need for police to be called upon discharge from the facility. She would have liked to have known prior to his admission.<br><br>During an interview on 9/14/23 at 11:29 a.m., SSD 1 indicated that normally, she does not have access to any hospital information prior to a resident's admission to the facility. SSD 1 was aware that | | | |

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| | Resident 310 had a history of SUD but was not made aware that he had actively been using illegal substances prior to his acute hospital admission. SSD 1 would have liked to have known prior to Resident 310's admission to the facility. SSD 1 was unable to assist with the care of resident's if she did not know the "whole story". SSD 1 would have put a plan into place upon admission if she had known the accurate history.<br><br>On 9/12/23 at 2:32 p.m., the AIT (Administrator in Training) provided the current Behavior Management General policy which read "...Policy: 1. It is the policy of the facility to identify and safely manage residents who are exhibiting behaviors related to psychiatric diagnoses or who may present a danger to themselves or others. 2. Resident will be provided with a resident centered behavior management plan to safely manage the resident and others. 3. Direct caregivers for residents who exhibit psychiatric, or dementia behaviors will receive in-service training on orientation, annually and as needed. Procedure: 1. Assess for problematic/ dangerous behaviors 2. Safety of the resident and others is a high priority...g. Problematic/ dangerous behaviors may include but are not limited to: i. Yelling/ screaming ii. Fighting<br>iii. cursing iv. arguing v. biting v1. posing a danger to self or others v11. threatening self or others...7. Complete a Care Plan a. Update with changes and/or new behaviors b. involve social service and activities department as appropriate c. review pharmacologic and non-pharmacologic interventions d. include resident specific interventions e. alert staff to changes f. discuss plan of care with resident and family..."<br><br>On 9/12/23 at 2:32 p.m., the AIT provided the Resident Substance Abuse in Facility policy, last | | | |

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| | revised 11/9/22, which read "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our resident, staff and visitors. The purpose of this policy is to provide guidance to the staff when substance use is confirmed or suspected in a resident and not intended to be a step-by-step procedure. Each resident will be provided care based on their individual medical and emotional needs and on their physical ability to self-perform or have assistance to perform the operation...The facility will safeguard the resident under the influence of illicit or illegal drugs to the extent possible, as well as provide a safe environment for other residents, staff, and visitors. This may include up to discharge of the substance abusing resident..."<br><br>On 9/12/23 at 2:32 p.m., the AIT provided the current Baseline Care Plan / 48 Hour Care Plan policy, which read "...The baseline or 48 hour Care Plan will include at a minimum: a. Healthcare information necessary to properly care for each resident immediately upon their admission...b. Identify need for supervision, behavioral interventions, and assistance with daily living...e. Provides for the resident's immediate health and safety needs...h. Includes Therapy and social services..."<br><br>4. The clinical record for Resident 39 was reviewed on 9/7/23 at 9:50 a.m. His diagnoses included, but were not limited to: vascular dementia, nicotine dependence, post-traumatic stress disorder, chronic pain syndrome, and anxiety disorder.<br><br>The 9/2/23, 3:07 a.m. nurse's note read, "Approximately 2:30 am when patient came back | | | |

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| | inside from smoking,I went into patient room to give pain pill. I stated to the patient that it was hydrocodone and is due at 2am. Patient said no, I asked again did he not want pain pill. He said no, patient then stated that he only takes medicine he can see be popped out. I gave patient a hydroxyzine at 23:00 with no issues or asking for me to pop out medication in front of the patient. Patient stated all his medication was to be done in front of him, I explained I did not know that because I had never had to do that for the patient before. I apologize and stated how I wouldn't be able to do that for this medication because I had already popped it out and told patient I could do it for future medications and would communicate to next shift as well. Patient opened his hand so I assumed after what I stated he would now take pain medication, patient then took the cup and did not take medication said he would hold on to it until morning. I stated to patient that he could not have medication stay in the room that he would have to either take the medication or I would have to waste it. Patient stated no began yelling, I then took the medication cup with the hydrocodone. Patient then hit me in the stomach and stood up. I walked out the room and then alerted the nigh [sic] supervisor of the situation."<br><br>The 8/17/23 Admission MDS (Minimum Data Set) assessment indicated Resident 39 had a BIMS (brief interview for mental status) score of 13, indicating he was cognitively intact.<br><br>An interview and observation was conducted with Resident 39 on 9/7/23 at 9:58 a.m. in the smoking area of the facility. He appeared upset while patting his stomach with his hands and indicated he felt assaulted by LPN (Licensed Practical Nurse) 5, who was also in the smoking area at this time. He was pointing at LPN 5, who | | | |

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| | was assisting another resident in the smoking area. He indicated it happened last Saturday, 9/2/23, and he told everyone about it and filed a grievance. At this time, Resident 39 provided a 9/5/23 Grievance/Complaint Form that he had on him.<br><br>The 9/5/23 Grievance/Complaint Form read, "Nurse aggressively searched inside my pockets without permission for medication I did not have."<br><br>On 9/7/23 at 9:56 a.m., an interview was conducted with the ED (Executive Director) who provided a copy of the 9/5/23 Resident Rights In Service Sign in Sheets and curriculum at this time. He indicated Resident 39 did not report this incident as abuse and kept changing his story. Education was provided to staff in regards to not searching a resident without permission. Resident 39 was planning to leave the facility LOA (leave of absence) on that day, but changed his mind after having been provided with his medications for the day, including narcotics. He did not go, so the nurse asked for the medications back, but he refused to give them back.<br><br>An observation and interview was conducted with Resident 39 on 9/7/23 at 12:08 p.m. While rubbing his stomach, he indicated LPN 5 aggressively searched him. He stated, "She cant grab me," and wanted he arrested. He didn't care if she was searching for pills. She should have called the police and had them search her. It wasn't her job to do that.<br><br>The 9/2/23, 8:11 a.m. behavior note read, "Resident not in pleasant mood this shift and not cooperative with nursing staff. Resident stated at 9am that he would be leaving LOA with his family and would need all his medication for the day. | | | |

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| | Around 2pm resident was still in facility, at this time writer educated resident that if he was not going LOA that writer would need the medication back and will admin [administer] at HS [noc] d/t [due to] narcotics in evening medication. Resident refused and became verbally aggressive and physical aggressive trying to push writer out the way with w/c [wheel chair.] At this time writer found other medication packets in his bookbag on w/c that resident had been saving. Resident is being dishonest saying he is leaving LOA to keep medication for the day. Management updated about occurrence. Will continue with current plan of care."<br><br>An interview was conducted with LPN 5 on 9/11/23 at 10:43 a.m. She indicated she was currently off work, because Resident 39 made an allegation that she inappropriately searched him. Earlier in the day, Resident 39 informed her that he was going LOA with family. She'd also received information in report from the previous shift's nurse that that he would say he was going LOA, but keeping his medications. LPN 5 took his word for it that day, that he would be going LOA, and gave him his medications around 8:30 a.m. for the day to last through 10:00 p.m. Around 2:00 p.m., she saw that he was still in the facility. When she saw him, she told him he could not keep the medications, if he was not leaving. Resident 39 became upset with her, asking why he had to give the medications back. She educated him that she could administer them, since he was still in the facility and that narcotics were to be kept on the medication cart. She would give the medications back to him, if he went out. Resident 39 "started charging at me with his wheel chair to get out of his pathway." This was occurring in the hallway. Another staff member, CNA (Certified Nursing Assistant) 28, intervened, trying to diffuse the | | | |

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| | situation. Resident 39 had a fanny pack on his wheel chair and you could see what was inside, because it was opened. When she gave him the medications at 8:30 a.m., they were in a packet and she saw him put the packet in the fannypack. She saw the packet, but the medications were not the medications she gave him at 8:30 a.m. that morning. They were from several days prior. She never touched him and she never got the medications back that she gave him that day. She did retrieve 5 packets of medications from the fanny pack, but they were from a previous day, which included 3 Hydrocodone 5/325s and 2 Lyrica. She did not want him to be walking around with narcotics, especially given some of the things she'd heard, him not leaving when he said he was, and not giving medications back when asked. Afterwards, staff was inserviced on resident rights, she believed in regards to this and other situations with Resident 39.<br><br>An interview was conducted with CNA 28 on 9/11/23 at 1:42 p.m. She indicated LPN 5 was trying tell Resident 39 that she needed the pills back, because she thought he was going to leave. This occurred way after 2:00 p.m., by the back door near the therapy department. Resident 39 was by the door, waiting on his ride. LPN 5 was telling him she needed the medication back. Resident 39 was saying "no, no, no." LPN 5 grabbed plastic bags of pills, 3 or 4 of them, from his wheel chair, opened the packets and said they were not the pills she gave him earlier that day, so she held onto them. Resident 39 was cussing. "He kept saying leave me alone, but she didn't touch him." Eventually his ride came and he left the facility that day.<br><br>An interview was conducted with the ED on 9/12/23 at 10:49 a.m. He indicated the inservicing | | | |

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| | was done as a result of the searching.<br><br>An interview was conducted with the DON (Director of Nursing) on 9/12/13 at 10:16 a.m. She indicated generally, residents told nursing if they would be leaving for the day and when they were coming back. The nurse could look to see what medications they would be taking and send the medication with them. The medications would be given to the resident, unless they had a guardian. The medications should be given to a resident upon leaving. As far as the Resident Extended Leave of Absence with Medications policy, she guessed Resident 39's physician was not notified in advance and no release of responsibility was signed, because it was not an extended leave, 24 hours or greater. She understood the medications were in his possession at the time LPN 5 took them from him. It could have gone the other way and he left the facility, when he said he was going to, and all of this wouldn't even have happened. They administered his medications when he was there and LPN 5 took his word for it that he was leaving the facility when he said he was going to leave. Sure, she received report about him being dishonest and some behaviors, but what was wrong with her taking his word for it and having a clean slate with him.<br><br>The Resident Extended Leave of Absence with Medications policy was provided by the ED on 9/11/23 at 12:24 p.m. It read, "Extended Leave of Absence: For the purpose of this policy, means when a resident leaves the facility for 24 hours or greater with consent from the primary provider, not as a discharge but as a therapeutic leave with the full intention of returning to the facility....Due to insurance regulations that limit the number of prescriptions written for a medication during specific time frames, residents will need to take | | | |

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| | their medications with them...The physician/provider will be notified in advance and will determine which medications and how many, including controlled substances will be permitted to be given to the resident for home visits....The resident/representative will sign a Release of Responsibility form for leave of absence with medications."5. The clinical record for Resident 99 was reviewed on 9/14/23 at 11:31 a.m. The resident's diagnoses included, but was not limited to, major depressive disorder and paraplegia.<br><br>A care plan dated 11/5/21 for Resident 99 indicated "...mood problem disease...interventions: Administer medications as ordered...Encourage to maintain as much independence and control/decision making as possible..."<br><br>A behavior care plan dated 5/16/22 indicated "Approach, speak in calm manner...Communicate with resident/resident representative regarding behaviors, and treatment...Intervene as necessary to protect the rights and safety of others...Minimize potential for disruptive behaviors by offering tasks that divert attention...Monitor behavioral episodes, and attempt to determine underlying causes...Notify medical provider of increased episodes of behaviors..."<br><br>A behavior note for Resident 99 dated 8/17/23 indicated "CNA [Certified Nursing Aide] approached writer and stated resident was waiting on HS [night] medication. When writer entered resident room, marijuana smell noted. Writer asked did resident call for medications? Informed resident nursing staff wasn't made aware of any request from resident. Resident became upset when writer explained about the | | | |

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| | miscommunication. Normally resident will come to nurse and make needs and requests known. Around 5 minutes later resident approached writer in a very aggressive manor and tone stating if writer said anything else to him that he would 'go the f*** off, resident making physical threats and stated this was writer fare warning!' Resident educated at this time that threating staff and using inappropriate language is completely inappropriate. Res [resident] stated, 'I don't give a f***, I don't like you' and continued to make aggressive threats to writer. Resident not easily redirected at this time, after several attempts to educate resident on appropriate conversations with nursing staff, res finally left nursing station. Resident in common smoking area at this time, will continue with current plan of care."<br><br>A behavior note dated 9/10/23 indicated the "resident shouted loudly 'I need a pain pill!'...Resident was informed nicely that medications were being counted and he would receive analgesic with assessment in a few minutes... resident screaming 'They know I was shot and bullets are still in my body!' 'These b****** know I hurt!'..."<br><br>The resident's clincal record did not include new interventions to address the resident's behavior.<br><br>An interview was conducted with the Social Services Director 2 on 9/14/23 at 1:05 p.m. She indicated the resident's plan of care should be revised with new interventions to address behaviors.<br><br>3.1-37(a)<br>3.1-43-(a)(1) | | | |

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| F 0761<br>SS=E<br>Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>Based on observation, interview and record review, the facility failed to ensure medications stored in the medication carts and medication rooms were labeled with the residents' names, dated with open dates, not expired, and discharged residents' medications removed for 4 of 8 medications carts and 2 of 4 medication rooms observed. (Residents 1, 11, 15, 24, 46, 56, 92, 123, 143, and 351)<br><br>Findings include: | F 0761 | A) No residents were harmed by the deficient practice. Residents 1, 11, 15, 24, 46, 56, 92, 123, 143, and 351 medications were labeled, removed, or destroyed as appropriate.<br>B) All residents have the potential to be affected. An audit was done all medication carts and medication rooms to ensure discontinued medications removed | 10/27/2023 |

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| | 1. Medication Carts<br>a. An observation was made of a Windsor unit medication cart with Qualified Medication Assistant (QMA) 8 on 9/11/23 at 10:48 a.m. The medication cart was observed included, but was not limited to the following medications:<br><br>1 opened Lantus insulin pen - labeled with Resident 11's name, but no opened date on pen<br>1 opened Humalog insulin pen - labeled with Resident 11's name, but no opened date on pen<br>1 opened artificial tears bottle- labeled with Resident 46's name, but no opened date on bottle<br>1 opened prednisolone 1% opthamolic solution bottle- labeled with Resident 46's name, but no opened date on bottle<br><br>b. An observation was made of a Cambridge South unit medication with Licensed Practical Nurse (LPN) 10 on 9/11/23 at 11:46 a.m. The medication cart was observed included, but was not limited to the following medications:<br><br>1 opened albuterol sulfate inhaler in a box- box labeled with Resident 56's name, but no resident name on inhaler itself<br>1 opened bottle of fluticasone nasal spray in a box- box labeled with Resident 15's name, but no resident name on bottle itself<br><br>c. An observation was made of a Cambridge unit medication cart with Licensed Practical Nurse (LPN) 3 and IP (Infection Preventionist) on 9/11/23 at 11:58 a.m. The medication cart was observed included, but was not limited to the following medications:<br><br>1 opened Breo inhaler in a box- the box was labeled with Resident 92's name, but no resident | | from carts and med rooms, narcotics double secured, unlabeled medications destroyed, and medications dated on both container and medication unit.<br>C) Nurses and QMA's were educated on facility policies "Storage of Medication" and "Discontinued Medications".<br>D) Facility will complete an audit on medication rooms and medication carts daily for 4 weeks, then 5 days a week for 8 weeks, then 3 times a week for 12 weeks to ensure discontinued medications have been removed, narcotics double secured, unlabeled medications destroyed, and medications dated on both container and medication unit. Any discrepancies will be immediately corrected, and re-education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. | |

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| | name on the inhaler itself<br>4 unidentified, loose tablets were located in the 3rd medication cart drawer<br>1 opened bottle of aluminum hydroxide-magnesium hydroxide-simethicone (generic Maalox)- labeled with Resident 24's name, but no opened date<br>1 opened vial of lorazepam (anti anxiety medication) in a plastic bag- the plastic bag was labeled with Resident 1's name, but no opened date and no resident information vial itself<br><br>2. Medication rooms<br>a. An observation of the Windsor medication room was conducted on 9/11/23 at 11:00 a.m. with LPN 23. The medication room observed included, but was not limited to the following medications:<br><br>In a drawer in the medication room were 5 lidocaine patches, but no resident label<br><br>In the medication fridge: was an unopened Basaglar pen- labeled for Resident 349, but was discharged on 9/19/22; a clear, locked box containing 2 unopened lorazepam 2 mg/ml (milligram per milliliter) bottles, but the locked, clear box was not permanently affixed inside the refrigerator.<br><br>b. An observation of the Regent units medication room was conducted on 9/11/23 at 11:17 a.m. with LPN 9. The medication room observed included, but was not limited to the following medications:<br><br>In the fridge: 1 unopened, expired Aspart insulin pen- labeled with Resident 143's name, but Resident 143 was discharged on 8/14/23<br><br>In a drawer in the medication room were:<br>13 unopened vials of heparin- labeled for Resident | | | |

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| | 123, but the order for heparin was discontinued on 12/30/22<br>1 unopened vial of ceftriaxone (an antibiotic)- labeled with Resident 143's name, but Resident 143 was discharged on 8/14/23<br>2 boxes of Narcan 4 mg nasal spray (which contain two bottles in each box), but no resident labels<br>1 opened vial of Haldol Decanoate (medication for Schizophrenia)- labeled with Resident 45's name, but order was discontinued on 4/16/23<br>2 unopened vials of ceftriaxone 1 gm (gram), but no resident labels<br>2 boxes of Narcan 4 mg nasal spray- labeled with Resident 351's name, but Resident 351 was discharged on 10/20/22<br>1 unopened bottle of artificial tears, but no resident label<br>1 opened vial of Narcan 0.4 mg/1 ml, but no resident label with an expiration date of 3/23<br>1 unopened vial of Narcan, but no resident label with an expiration date of 3/23<br>1 unopened vial of Nitroglycerin tablets, but no resident label<br>1 unopened bottle of Moxifloacin 0.5 mg eye drops, but no resident label with an expiration date of 7/23<br>20 unopened vials of Lasix (a diuretic), but no resident labels with an expiration date of 3/1/22<br>1 opened vial of lidocaine 1%- labeled with Resident 143's name, but resident discharged on 8/14/23<br><br>An interview with DON (Director of nursing) was conducted on 9/11/23 at 2:09 p.m. DON indicated, the facility does not have "floor stock" medications at the facility; and was unaware of the controlled medications stored in the unit refrigerators needing to be permanently affixed. | | | |

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| | A Storage of Medication Policy, effective on 9/18 and last revised on 8/20, was received from DON on 9/8/23 at 10:20 a.m. It indicated, "1. The provider pharmacy dispenses medication in container that meets regulatory requirements, including standards set forth by the United States Pharmacopoeia. Medications are kept in these containers...8. Outdated, contaminated, or deteriorated medications...are immediately removed from inventory, disposed of according to procedures for medication disposal...5. When the original seal of manufacturer's container or vial is initially broken, the container or vial will be dated. a. The nurse shall place a "date opened" sticker on the medication and record the date opened and the new date of expiration...7. No expired medication will be administered to a resident. 8. All expired medications will be removed from the active supply and destroyed in accordance with facility policy, regardless of amount remaining."<br><br>A discontinued medication policy, effective 9/18 and last revised on 8/20), was received on 9/11/23 at 1:39 p.m. from DON. It indicated, "When medication are discontinued by the prescriber or the resident is discharged and medications are not sent with the resident, the medications are marked as discontinued and stored in a secure and separate area from the active medications until destroyed ...or returned to the pharmacy..."<br><br>3.1-25(b)<br>3.1-25(j)<br>3.1-25(k)<br>3.1-25(n)<br>3.1-25(o)<br>3.1-25(q) | | | |
| F 0803 SS=D | 483.60(c)(1)-(7)<br>Menus Meet Resident Nds/Prep in | | | |

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| Bldg. 00 | Adv/Followed<br>§483.60(c) Menus and nutritional adequacy. Menus must-<br><br>§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;<br><br>§483.60(c)(2) Be prepared in advance;<br><br>§483.60(c)(3) Be followed;<br><br>§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;<br><br>§483.60(c)(5) Be updated periodically;<br><br>§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and<br><br>§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.<br><br>Based on observation, interview, and record review, the facility failed to honor food choices of a resident for 1 of 1 resident reviewed for choices (Resident 89).<br><br>Findings include:<br><br>The clinical record for Resident 89 was reviewed on 9/6/23 at 1:17 p.m. The Resident's diagnosis included, but were not limited to, diabetes.<br><br>A Quarterly MDS (Minimum Data Set | F 0803 | A) Resident 89 was not harmed by the deficient practice. Resident 89 food preferences were updated by the dietary manager at the time the resident expressed a change.<br>B) All residents have the potential to be affected. Interviewable residents will be interviewed to ensure food preferences are current and updated on residents' meal tickets.<br>C) Staff were educated on facility policy "Dining and Food | 10/27/2023 |

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| | Assessment), completed 8/4/23, indicated Resident 89 was cognitively intact.<br><br>On 9/6/23 at 1:17 p.m., Resident 89 was observed sitting in his room with his lunch tray on his bedside table in front of him, with a meal ticket on the tray that listed dislikes as pork, beef, and grilled cheese and to send chicken, fish, or turkey, chef salad instead. CNA (Certified Nursing Assistant) 30 entered the room to pick up Resident 89's lunch tray. CNA 30 took the lid off of the tray and asked Resident 89 if he was finished. Resident 89 asked CNA 30 why his ravioli did not come with any sauce on it. CNA 30 indicated the sauce had meat in it and offered a substitute of a cheeseburger or grilled cheese. Resident 89 declined the offered substitutes.<br><br>During an interview on 9/6/23 at 1:20 p.m., Resident 89 indicated he was a partial vegetarian and had not eaten pork or beef since 1972. Resident 89 had made the kitchen staff aware that he did not like grilled cheese and was frustrated because he was always offered either a grilled cheese or a cheeseburger as a substitute, but he did not eat either of them. Resident 89 also did not like egg salad and kept getting it as well. He had attended food council meetings and had let the kitchen staff know of his preferences but kept getting offered items he did not like as a substitute.<br><br>During an interview on 9/14/23 at 1:31 p.m., Resident 89 indicated he had gotten an egg salad sandwich for lunch and was frustrated because he had told the kitchen that he didn't like egg salad. He has asked for chicken or fish as a daily alternative, but his request had not been honored. He had been served peanut butter and jelly for lunch the day before, but he didn't eat those | | Preferences" with an emphasis on ensuring offered substitutions are not on the residents' dislikes.<br>D) Resident interviews will be conducted weekly to identify any concerns with food preferences. 5 residents will be interviewed weekly x 4 weeks by dietary manager or designated representative, then 3 residents weekly x 4 weeks, then 5 residents monthly x 4 months. Any discrepancies will be immediately corrected, and re-education will be provided. Results of the audit will be brought to QAPI for 6 months or until 100% compliance has been achieved. | |

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| | either.<br><br>During an interview on 9/14/23 at 3:17 p.m., the Dietary Manager indicated that Resident 89 changed his preferences often and she updated his tray card with the preferences each time she was made aware of a change. She was not aware that Resident 89 did not like egg salad but would update his card now that she knew. The dietary manager was not aware that he when he refused foods, he was often offered grilled cheese or a cheeseburger. She had not been made aware that Resident 89 had refused his egg salad at lunch and that if the nursing staff would make the kitchen aware of refusals, the kitchen would send an alternative that Resident 89 would prefer.<br><br>On 9/14/23 at 3:42 p.m., the Administrator in Training provide a copy of Resident 89's most recent tray card which indicated he did not want pork, beef, cheese, or ham. He would eat turkey sausage at breakfast. He was to be sent chicken, fish or turkey chef salad on days which beef or pork was served.<br><br>On 9/14/23 at 3:42 p.m., the Administrator in Training provide the Dining and Food Preferences policy, last revised 9/2017, which read "...7. The individual tray assembly ticket will identify all food items appropriate for the resident/ patient based on diet order, allergies & intolerance's and preferences. 8. Upon meal service, any resident/ patient with expressed or observed refusal of food and/ or beverage will be offered an alternate selection of comparable nutrition value. 8. The alternate meal and/or beverage selection will be provided in a timely manner..." | | | |
| F 0880 SS=D | 483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control | | | |

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| Bldg. 00 | §483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to: | | | |

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| | (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>Based on observation, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and prevent the transmission of communicable diseases and infections by not disposing of a lancet properly, wearing gloves when administering insulin, using only one alcohol pad to cleanse two different locations for | F 0880 | A) Residents 2 and 59 were not harmed by the deficient practice. Staff were educated on the deficient practices immediately.<br>B) All residents have the potential to be affected by the deficient practices. Education and observations were initiated to ensure staff compliance with infection prevention and control | 10/27/2023 |

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| | subcutaneous injections, and not performing hand hygiene after removal of gloves for 1 of 2 residents observed during medication administration (Resident 59) and 1 of 2 residents reviewed for transmission-based precautions (Resident 2).<br><br>Findings included:<br><br>1. An observation of Resident 2's room was conducted on 9/7/23 at 2:48 p.m. Resident 2's room had two signs on her door. One sign indicated the room was under contact precautions-droplet isolation (yellow stop-light sign) and the other sign indicated contact precautions. The door also had an isolation station hanging on the door with personal protection equipment (PPE) stored in it.<br><br>During the observation, HSK (housekeeper) was preparing to go into Resident 2's room. HSK donned an isolation gown, gloves, and a mask then entered the room. She later came out of Resident 2's room to the housekeeping cart which was in front of Resident 2's doorway. HSK reached under her isolation gown still wearing the same gloves, and retrieved some keys. She rifled through the housekeeping cart for a moment, replaced the keys on her person, and re-entered the room. HSK then went into Resident 2's bathroom, retrieved the garbage, and placed the trash inside the housekeeping cart while still wearing the same PPE. When exiting the room, she removed the mask first, then her gloves, and finally took off the isolation gown and placed them in the trash compartment in the housekeeping cart. HSK did not doff the PPE correctly nor did she perform hand hygiene after removing her gloves or after disposing of the isolation gown. HSK then grabbed a broom from | | policies.<br>C) Staff were inserviced on facility policies “Standard Precautions”, “Biohazardous Waste Management Plan”, and “Injection Subcutaneous” with an emphasis on proper disposal of lancets, wearing gloves when administering injections, using separate alcohol swabs for multiple injections, and performing hand hygiene after removal of gloves.<br>D) Facility will complete observations daily for 4 weeks, then 5 days a week for 8 weeks, then 3 times a week for 12 weeks to ensure. proper disposal of lancets, wearing gloves when administering injections, using separate alcohol swabs for multiple injections, and performing hand hygiene after removal of gloves. Any discrepancies will be immediately corrected, and re-education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. | |

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| | the cart, pushed the cart down the hallway, and entered another resident's room without performing hand hygiene.<br><br>An interview with LPN (Licensed Practical Nurse) 3 was conducted on 9/7/23 at 3:13 p.m. LPN 3 was Resident 2's nurse for the day. LPN 3 indicated, having two different isolation signs on the door was very confusing as they did not say the same thing. She was unaware why Resident 2 was under isolation precautions.<br><br>An interview with IP (Infection Preventionist) conducted on 9/7/23 at 3:18 p.m. indicated, Resident 2 was no longer on isolation precautions. IP stated, "it was from a while ago", but she still should have done hand hygiene after removing gloves and/or prior to entering a residents room.<br><br>A review of Resident 2's clinical record was conducted immediately following the interview with IP. Resident 2 had been diagnosed with ESBL (Extended-spectrum beta-lactamase Esherichia coli, an anti-biotic resistant bacteria) in her urine in July 2023.<br><br>2. An observation of a blood sugar check for Resident 59 was conducted on 9/8/23 at 9:20 a.m. with LPN 7. After performing a blood sugar check on Resident 59, LPN 7 had placed the used lancet on a paper towel and then grabbed the paper towel with her gloved hand and proceeded to remove her gloves so that the contents in her hand was inside the inside-out glove. LPN 7 then tossed the used gloves in her trash receptacle on the medication cart. LPN 7 failed to place the used sharp in the sharps container. | | | |

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| | 3. An observation of insulin administration for Resident 59 was conducted on 9/8/23 at 9:20 a.m. with LPN 7. After performing the blood glucose check on Resident 59, LPN 7 prepared two insulin pens for administration. Resident 59 was to receive 4 units of Lantus via insulin pen and 4 units of Lispro insulin. LPN 7 entered Resident 59's room and explained what she was going to do and asked if the resident wanted to sit down for the injections, but the resident refused and remained standing. Without any gloves on, LPN 7 opened one alcohol pad and wiped one location on the resident's abdomen and she then administered the first injection. LPN 7 then again grabbed the same alcohol pad that was previously used and wiped a second location on the resident's abdomen and injected the insulin.<br><br>A Standard Precautions policy, effective 10/21/14 last revised on 4/1/17 and last reviewed on 6/24/21, was received on 9/14/23 at 4:26 p.m. from DON (Director of Nursing). It indicated, "When to perform Hand Hygiene...B. Before and after direct contact with a residents intact skin...after contact with inanimate objects including medical equipment in the immediate vicinity of the residents...before care between residents...after glove removal..."<br><br>A BioHazardous Waste Management Plan, effective on 8/1/21 and reviewed on 8/2/21, was provided by DON on 9/8/23 at 10:12 a.m. It indicated, in the section BioHazardous Waste Assessment, lancets should be collected in rigid containers. Containers should be puncture-proof and fitted with covers."<br><br>An Injection Subcutaneous policy was received on 9/8/23 at 10:12 a.m. from DON. It indicated, "Prepare for the procedure...d. Perform hand | | | |

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|---|---|---|---|
| | 155334 | A. BUILDING 00<br>B. WING | 09/14/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WILDWOOD HEALTHCARE CENTER | 7301 E 16TH ST<br>INDIANAPOLIS, IN 46219 |

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| | hygiene and don gloves...iii Cleanse selected injection site with alcohol wipe using a circular motion..."<br><br>3.1-18(b)<br>3.1-18(l) | | | |
| F 0921 SS=E Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br>Based on observation and interview, the facility failed to ensure a safe, functional, sanitary, and comfortable environment for residents by: room curtains not properly hung or torn from hooks, holes in a residents' room wall, a fly strip hanging in a residents room, cracked and discolored ceilings, buckled ceilings in hallway, room thresholds taped down, baseboard not affixed to wall, missing dresser drawer and dried food on walls for residents who reside on the 100, 200, 300, and 700 hallways.<br><br>Findings include:<br><br>An environmental tour was conducted on 9/14/23 at 2:06 p.m. with MM (Maintenance Manager), AIT (Administer in training), and ED (Executive Director). During the environmental tour the following observations were made:<br><br>- Resident 73's and Residents' 96 and 114's rooms had window treatments that were hung properly and/or torn from their hooks<br><br>- Residents' 116 and 80's room had a hole in the wall large enough to fit a shoe through | F 0921 | A No residents were harmed by the deficient practice.<br>B All residents have the potential to be affected. A facility tour was completed, identified items to be repaired/attended to by maintenance/designee.<br>C Maintenance director and housekeeping were educated on safe, functional, sanitary, and comfortable environment for residents with an emphasis on room curtains, holes in walls, fly strips, damaged ceilings, room thresholds, dressers, baseboards, and wall cleanliness.<br>D Facility will complete observations daily for 4 weeks, then 5 days a week for 8 weeks, then 3 times a week for 12 weeks to ensure safe, functional sanitary environment with an emphasis on room curtains, walls, no fly strips, ceilings, thresholds, dressers, baseboards, and wall cleanliness. Any discrepancies will be immediately corrected or have a | 10/27/2023 |

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| | - Resident 134's room had a sticky, fly strip hanging in his room that he did not place himself<br><br>- The "00" hallway has two areas were the ceiling appears to be falling down/buckled<br><br>- Residents' 107 and 126's threshold into their room is taped down with black tape<br><br>- Residents' 96 and 114's baseboard in the bathroom was ripped off the wall<br><br>- Resident 60's dresser was missing a drawer<br><br>- Resident 59's ceiling contains a large crack with discoloration<br><br>- Resident 7's wall under her TV has dried yogurt on it<br><br>An interview with ED conducted on 9/14/23 at 2:34 p.m. at the end of the environmental tour indicated, all items observed should be repaired and/or replaced, and cleaned.<br><br>3.1-19(f)<br>3.1-18(m)(4) | | work order established, and re-education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. | |
| F 0926 SS=D Bldg. 00 | 483.90(i)(5)<br>Smoking Policies<br>§483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents.<br>Based on observation, interview, and record review, the facility failed to ensure residents extinguished cigarettes in proper receptacles. This had a potential to affect 64 of 64 residents that | F 0926 | A No residents were harmed by the deficient practice.<br>B All residents have the potential to be affected. Smoking | 10/27/2023 |

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| | smoke.<br><br>Findings include:<br><br>Observations were made of the designated smoking area in the courtyard on 9/07/23 at 10:52 a.m., 9/11/23 at 9:30 a.m., and 9/11/23 at 7:52 p.m. The courtyard was observed with multiple cigarette butts all over the ground.<br><br>An observation was made of the smoking area in the courtyard with the Executive Director on 9/13/23 at 1:51 p.m. There were multiple cigarette butts observed all over the ground in the courtyard. There were ashtrays observed on the porch and in the gazebo.<br><br>An interview was conducted with the Executive Director on 9/13/23 at 2:00 p.m. He indicated the staff sweep up the cigarette butts several times a day.<br><br>A smoking guidelines policy was provided by the Executive Director on 9/12/23 at 9:00 a.m. It indicated "...It is the policy of this facility to promote resident centered care by providing a safe smoking area for residents that request to smoke and are capable of safe smoking behaviors either independently or with supervision unless the facility is a designated non-smoking facility...10. Safe designated smoking area(s) will include immediate access to:..c. Appropriate Safety Ashtrays i. Quantity appropriate for volume of smokers, ii. safety features such as non-combustible material, heavy to avoid tipping. iii. Regular emptying of ash trays by staff into appropriate receptacles..." | | areas were cleaned and all cigarette butts in the grass were disposed of properly. Additional ashtrays were purchased and placed in the smoking area.<br>C Staff and smoking monitors were educated on facilities policy "Smoking Guidelines" with an emphasis on cleaning up cigarette butts. Smoking monitors educated on new cleaning schedule. Residents were educated on proper disposal of cigarette butts.<br>D Facility will complete observations daily for 4 weeks, then 5 days a week for 8 weeks, then 3 times a week for 12 weeks to ensure smoking area has extinguished cigarettes placed in proper receptacles. Any discrepancies will be immediately corrected, and re-education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. | |