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	155829	A. BUILDING 00 B. WING	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGS AT LAFAYETTE, THE	2402 SOUTH STREET LAFAYETTE, IN 47904

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Nursing Home Complaints IN00372237 and IN00369472. Complaint IN00372237 - Substantiated. Federal/State deficiencies related to the allegations are cited at F550. Complaint IN00369472 - Substantiated. Federal/State deficiencie related to the allegations are cited at F676. Survey dates: August 1, 2, 3, 4, 5, 8 and 9, 2022. Facility number: 013499 Provider number: 155829 AIM number: 201285490 Census Bed Type: SNF/NF: 22 SNF: 39 Residential: 29 Total: 90 Census Payor Type: Medicare: 23 Medicaid: 18 Other: 20 Total: 61 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on August 17, 2022.	F 0000	The submission of this plan of correction does not indicate an admission by The Springs at Lafayette Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of The Springs at Lafayette Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	

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

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F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his			

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	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 interview and record review, the facility failed to ensure a resident was free of staff using their cellular phone on face time while in the resident's room for 1 of 3 residents reviewed for respect and dignity. (Resident C) Finding includes: During an interview, on 8/2/22 at 11:13 a.m., Resident C indicated about a year ago a female staff who was no longer employed at the facility, was on face time while she was helping her go to the bathroom. She told the staff nurse on duty what happened and the nurse talked to the administrator. The staff who used her phone in the room came back and told Resident C she was on the phone with her husband and he was not able to see the resident on the toilet. Resident C did not give the name of the staff and indicated she did not want to complain about the staff. The record for Resident C was reviewed on 8/4/22 at 12:07 p.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), fatigue, hypothyroidism, fibromyalgia, autoimmune thyroiditis, chondromalacia patellae (damage to the knee cap), abdominal pain and osteoarthritis. A BIMS (brief interview for mental status) completed on 7/6/22 was 15 which indicated intact cognition. A care plan, dated 8/7/19, indicated the resident had impairment in functional status in regards to bed mobility, transfers and toileting related to her weakness. The interventions included, but were	F 0550	1. Staff listed in the mentioned occurrence is no longer employed at the facility. 2. Social Service and/or designee will interview all resident to determine if any other residents have concerns with staff cell phone usage or other concerns. These concerns will be reported to the DHS, ED and/or designee. Immediate action for concerns will be addressed with staff. 3. Social Service and/or designee will randomly audit 5 residents per week for any concerns or issues for 4 weeks, then 5 residents every other week for 4 weeks and then 5 residents a month for 4 months. All concerns are to be logged on a concern form and reviewed with the ED. The resident concerns will be addressed immediately. 4. Staff to be re-inserviced to cell phone usage, code of conduct and resident rights. Substantial compliance will be achieved by 9/12/2022.	09/12/2022

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	not limited to, the resident required extensive assist with toileting. During an interview, on 8/4/22 at 11:52 a.m., CRMA (certified resident medication aide) 10 indicated, GCRCA (graduate certified resident care assistant) 11, had been fired for using her cellular phone. She was face timing while she was in the residents' rooms. During an interview, on 8/4/22 at 11:59 a.m., LPN 2 indicated GCRCA 11 was very loud and made everyone uncomfortable and was reported to the administration several times for using her phone and being on face time. LPN 2 also requested her to stop using her phone. GCRCA 11 had used her phone while in Resident C's room while she was assisting her to the toilet. This was reported to the scheduler who was now the payroll staff. During an interview, on 8/4/22 at 12:19 p.m., the payroll staff indicated GCRCA 11 was reported to have been on her phone and did a video call when she was on duty. She did not handle the situation and did not know where GCRCA 11 was located when she made the video call. During an interview, on 8/4/22 at 3:47 p.m., with the Administrator and the DHS (Director of Health Services), the Administrator indicated GCRCA 11 was terminated due to leaving the facility in the middle of the shift to go on break and did not come back. During March 2022, there were a lot of complaints about GCRCA 11 using her cellular phone on the floor. There were no complaints from residents about the use of cellular phones by staff. The Administrator did not interview residents about the staff use of cellular phones. The DHS indicated when she first was employed, she had issues with staff carrying cellular phones			

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	and GCRCA 11 indicated she had used her cellular phone while working due to an upcoming court case. GCRCA 11 always took her break at 4:00 p.m., and did not come back one evening after her break. There were no reports of GCRCA 11 being in residents' rooms using her cellular phone. A Personnel Action Form, dated 5/16/22, indicated GCRCA 11 was terminated effective 5/14/22 for job abandonment due to walking out in the middle of her shift and not returning. The termination was approved by the Administrator on 5/16/22. A current policy, titled "Resident Rights Guidelines," dated as revised 5/11/17 and received at entrance from the Administrator, indicated "...To ensure resident rights are respected and protected and provide an environment in which they can be exercised...Residents shall not leave their individual personalities or basic human rights behind when they move to a health campus. The following is a list of rights recognized by staff at Trilogy Health Services...Be treated with dignity and respect...Privacy...Be treated fairly, courteously and with respect by staff...Be free of physical, verbal, fiduciary or psychological abuse from staff, family and other residents...Including all other state specific resident rights according to their public health code...." This Federal Tag relates to Complaint IN00372237. 3.1-3(p)(4)			
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental			

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	research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on record review and interview, the facility	F 0578	1. Resident affected code status	09/12/2022

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	failed to ensure a resident's code status had been updated for 1 of 4 residents reviewed for advanced directives (Resident 47). Finding includes: The record for Resident 47 was reviewed on 08/05/22 at 9:38 a.m. Diagnoses included, but were not limited to, hypertensive chronic kidney disease stage 3, unspecified protein malnutrition, COPD (chronic obstructive pulmonary disease), athrosclerosis, abdominal aortic aneurysm and peripheral vascular disease. The resident's face sheet on the electronic health record indicated full code status. A physician's order, dated 07/02/22, indicated the code status was full code. A care plan, dated 07/02/22, indicated the resident/resident representative had chosen a full code. Approaches included, but were not limited to, review the advanced directives quarterly and as needed. An advance directive form, dated 7/26/22 and signed by the resident's representative indicated DNR (do not resuscitate). The form was signed by the physician on 8/2/22. On 8/3/22 at 9:30 a.m., the SSD indicated a new post form and a physician's order was obtained for the DNR status. The face sheet was updated to included the new post form and physician's order. A current policy, titled, "Guidelines for Advanced Directive", dated 1/7/19 and received from the social services director on 8/9/22 at 11:00 a.m.,		and order were reviewed for accuracy. Resident signed a new code status order for full code. Matrix order reviewed and Care plan reviewed for accuracy. 2. All current resident code status and orders will be reviewed and compared to current orders and care plans. Inaccuracies will be corrected immediately with orders, code status and care plan records. 3. New admissions to be reviewed for accuracy of a completed code status, order and care plan to match. Any resident change in code status will be reported to the DHS/ADHS to ensure updates are made timely. 4. Random audits of 5 residents a week for 4 weeks, then 5 residents every other week for 4 weeks, then 5 residents a month for 4 months. All audits will be reviewed in the quarterly QAPI meeting for 6 months. Substantial compliance will be met by 09/12/2022.	

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	indicated, '...To ensure facility staff obtains and follows resident's advanced directives regarding end-of-life care...Advanced Directives will be reviewed with resident and/or resident representative by the Customer Service representative or designee at time of admission, with the quarterly comprehensive assessment and PRN [as needed]...The resident or representative will advise the CSR [customer service representative]/designee regarding wishes for end of life directives and code status. The 'DNR' form will be completed documenting these desires and scanned into the medical record...The nursing staff will obtain an order from the attending physician for the desired code status...Designation of code status and obtainment of physician order will be part of the medical record... 3.1-4(f)(4)(ii)			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. 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: §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. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual			

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	disability, or a related condition for level II resident review upon a significant change in status assessment. Based on record review and interview, the facility failed to ensure a PASARR (Preadmission Screening and Resident Review) was completed when the resident was prescribed an antipsychotic medication and given a mental health diagnoses of hallucinations for 1 of 1 residents reviewed for PASARR (Resident E). Finding includes: The record for Resident E was reviewed on 8/3/22 at 12:06 p.m. Diagnoses included, but were not limited, positive Covid-19, encephalopathy (a brain disease altering function or structure), dementia without behavioral disturbance, cerebral infarction and anxiety disorder. A PASARR level I, dated 4/26/22, indicated the resident was not on any antipsychotic medication. A physician's order, dated 6/30/22, indicated olanzapine (an antipsychotic medication) 5 mg (milligram) at bedtime related to encephalopathy. During an interview, on 8/9/22 at 10:06 p.m., the Social Service Director (SSD) indicated a PASARR Level I was not completed. The resident was on olanzapine 5 mg and she should have done a PASARR Level I. A current policy, titled "Indiana PASRR Standard Operating Procedure Revenue Billing & Collections," not dated and received on 8/9/22 at 5:06 p.m., from the Director Nursing Services (DNS) indicated "... Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are appropriately	F 0644	1. Resident E was reviewed and a PASRR will be completed for further changes. 2. Residents receiving antipsychotic medications will be reviewed for PASRR completion and documentation of appropriate diagnosis 3. All referrals will be assessed for a need of a PASRR on admission and will be completed timely per regulations. Any residents with new orders for antipsychotics will have a PASRR completed and ensure they have an appropriate dx for the medication(s). 4. Audits of 5 residents a week for 4 weeks, then 5 residents every other week for 4 weeks, then 5 residents monthly for 4 months will be completed by the SS and/or designee to ensure accuracy of all PASRR completions for and results reported in the quarterly QAPI meetings for 6 months. Substantial compliance will be met by 09/12/2022.	09/12/2022

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	placed in nursing facilities for long-term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness (SMI) and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings...Change in status and Level II follow up...Social Services ensures paperwork is submitted. They will print out the outcome letter and upload to Matrix file..." 3.1-16(d)(1)(A)			
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:			

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	§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on interview and record review, the facility failed to ensure showers were completed and documented for 3 of 3 residents reviewed for bathing (Residents B, D and E). Findings include: 1. During an interview, on 8/4/22 at 3:31 p.m., Resident B indicated when she was being isolated for Covid-19, she was not given assistance to shower for the first 14 days after being admitted to the facility. Different staff had told the resident they would come back to assist her to shower and then did not return. She received a shower on the last day of her isolation for Covid-19. The record for Resident B was reviewed on 8/3/22 at 2:18 p.m. Diagnoses included, but were not limited to, diverticulitis, colostomy status, cerebrovascular disease, depression, osteoarthritis, generalized muscle weakness and unspecified fall. A Point of Care (POC) ADL (activities of daily living) report, dated 11/6/21 through 11/30/21,	F 0676	1. Residents were reviewed for shower schedules. Care staff were re-educated regarding completion of documentation in Care assist. Resident profiles were updated to reflect the scheduled shower days for the residents. 2. All residents will be reviewed for shower schedules and care profiles to be updated to reflect resident shower days. Care staff to be educated to complete the documentation when completing the task in Care assist. 3. audits of 5 residents a week for 4 weeks, then 5 residents every other week for 4 weeks, then 5 residents a month for 4 months will be completed by the DHS/ADHS and/or designee completion of resident showers and reported in the quarterly QAPI meeting for 6 months. Substantial compliance will be met by 09/12/2022.	09/12/2022

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	indicated the resident did not have a bath or shower on 11/6/21,11/7/21, 11/8/21, 11/9/21, 11/10/21, 11/11/21 or 11/12/21. A comprehensive care plan, dated 11/23/21, indicated the resident was at risk for falling related to needing assistance with ADL care and the diagnoses of hypertension and depression. The interventions included, but were not limited to, two assist with transfers for showers during the acute infectious episode. During an interview, on 8/9/22 at 5:05 p.m., the Director of Health Services (DHS) indicated the resident did not have bathing preferences listed on the care plan and there was no documentation in the electronic health record of the resident receiving showers from 11/6/21 through 11/12/21. The resident went 7 days without having any documentation of a shower or bathing being completed.2. During an observation, on 8/8/22 at 3:50 p.m., Resident E was sitting at the nurses station. The resident's hair was dirty and not brushed. The record for Resident E was reviewed on 8/3/22 at 12:06 p.m. Diagnoses included, but were not limited, positive Covid-19, encephalopathy (a brain disease altering function or structure), dementia without behavioral disturbance, cerebral infarction and anxiety disorder. A Point of Care (POC) ADL report, dated 6/30/22 through 8/8/22, indicated the resident did not have a bath or shower on 7/4/22, 7/11/22, 7/28/22 and 8/8/22. A physician's order, dated 6/30/22, indicated admit to the facility for skilled level of care and services.			

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A care plan, dated 7/22/22, indicated the resident's profile care guide had showers scheduled for Tuesday and Friday on evening shift.

During an interview, on 8/8/22 at 4:00 p.m., CNA 9 indicated the resident's shower days were Monday and Thursday. The hospice aide gave her showers to her. She could only find record of 3 showers given to the resident.

3. The record for Resident D was reviewed on 8/5/22 at 12:08 p.m. Diagnoses included, but were not limited to, pneumonia, hypertension, depression and anxiety disorder.

A Point of Care (POC) ADL report, dated 7/20/22 through 8/8/22, indicated Resident D had 1 bed bath and 1 shower from 7/20/22 through 8/8/22.

A physician's order, dated 7/20/22, indicated to admit for skilled level of care and services.

A care plan, dated 8/3/22, indicated the residents profile care guide had showers scheduled for Monday and Thursday on nightshift.

During an interview, on 8/9/22 at 2:20 p.m., CNA 4 indicated if a resident was in isolation she would gather up all her supplies and go into the room. The showers were charted in the computer.

During an interview, on 8/9/22 at 2:56 p.m., the DHS indicated the residents with Covid-19 have their own room with a shower. The residents normally have showers twice a week. Once a shower was completed the CNAs were supposed to document the showers in point of care or on a shower sheet. The CNA would give the shower sheet to the nurse for review. The facility

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	155829	A. BUILDING 00 B. WING	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGS AT LAFAYETTE, THE	2402 SOUTH STREET LAFAYETTE, IN 47904

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	document, titled "Point of Care ADL Category Report (MDS 3.0)," indicated if the form was marked with an 8 the bathing was not done. Resident D was admitted on 7/20/22. The only bath she had received was on 7/26/22. A current policy, titled "Nursing ADL Documentation Guidelines," revised 5/10/16 and received from the DHS on 08/09/22 at 5:10 p.m., indicated "...Completion of ADL services will be validated through the use of the CARE ASSIST ADL reports...ADL services will be conducted and documented by the CNA each shift at the "point of care" or as reasonably possible after care...The paper format shall be submitted to the MDS Coordinator...." This Federal Tag relates to Complaint IN00369472. 3.1-38(b)(2)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to assess and document skin conditions for 2 of 3 residents reviewed for non-pressure skin conditions (Resident 16 and 34). Findings include:	F 0684	1. Residents affected were assessed and appropriate documentation noted, MD and family were notified and no other concerns were found. 2. Complete skin assessments were completed on all residents	09/12/2022

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	1. During an observation, on 8/1/22 at 3:54 p.m., Resident 16 had a purple colored area on his right hand about the size of a 50 cent piece. The record for Resident 16 was reviewed on 8/4/22 at 2:47 p.m. Diagnoses included, but were not limited to, chronic kidney disease stage 3, hemiplegia and hemiparesis following a cerebral infarction affecting the left non dominant side, altered mental status and contracture of the left hand. A physician's order, dated 6/28/22, indicated to monitor for signs and symptoms of bleeding and an increase or abnormal bruising every shift. A care plan, dated 7/12/19 and last revised on 6/7/22, indicated the resident was at a risk for excessive bleeding and bruising related to medications. The goal indicated the resident was to have no excessive bleeding or bruising. The interventions included, but were not limited to, administer medication as ordered by the physician and to notify the physician of abnormal bleeding or bruising. During an observation, on 8/8/22 at 4:01 p.m., with the clinical support nurse, the resident was noted to have multiple spots on his right hand with 5 reddened spots which were the size of a dime and one spot was the size of a 50 cent piece and appeared like a purplish bruise. There was also a skin tear above the spots on the hand which was covered with tape. During an interview, on 8/8/22 at 4:15 p.m., the clinical support nurse indicated there was no documentation in the electronic health record about the resident's right hand with the spots and		who could be affected with findings documented in the resident records, family and MDs notified. 3. Any resident with new skin impairments will have the concern documented in the event system, MD and family notified and follow up assessment to be completed per policy. Clinical staff to be in serviced to the Policy on skin impairments and documentation. 4. Audits of 5 residents a week for 4 weeks, 5 residents every other week for 4 weeks and 5 residents a month for 4 months by the DHS/ADHS and/or designee will be completed. Any findings will be corrected immediately. Audit results will be reported in the quarterly QAPI meeting for 6 months. 5. Substantial compliance will be met by 09/12/2022.	

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	skin tear. 2. During an observation, on 08/02/22 at 10:44 a.m., a dime size purple area was observed on the outer left hand and a quarter size bruise was on the left inner hand of Resident 34. The record for Resident 34 was reviewed on 08/03/22 at 11:40 a.m. Diagnoses included, but were not limited to, CHF (congestive heart failure), cardiomyopathy and NSTEMI (non ST elevation myocardial infarction). A care plan, dated 03/30/22, indicated the resident was at risk for bleeding and bruising. The interventions included, but were not limited to, observe for abnormal bleeding and bruising and to notify physician of changes. A physician's order, dated 08/05/21, indicated to monitor for signs and symptoms of bleeding, increased or abnormal bruising three times daily and notify the physician if symptoms occurred. A current physician's order, indicated to give Apixaban (a medication used to prevent blood clots) 5 mg (milligrams) twice daily and aspirin 81 mg daily. During an interview, on 8/03/22 at 3:38 p.m., LPN 2 indicated bruising would be noted in the event area of the chart. There was no event in the electronic record with the bruising noted. A current policy, titled "Guidelines for Weekly Skin Observation," dated 01/07/19 and received from Director of Health Services (DHS) on 08/05/22 at 4:18 p.m., indicated "...to monitor the effectiveness of intervention for pressure reduction, identify areas of skin impairment in the			

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	early development stage and implement other preventative and/or treatment measures as indicated...a full body observation shall be completed weekly by the licensed nurse...upon admission the admitting nurse shall include as part of the admission orders a weekly skin observation...initiate applicable Wound Event if new area of impairment is identified...." 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview and record review, the facility failed to assess and treat a resident for potential left foot drop for 1 of 5 residents reviewed for positioning and limited range of motion (Resident 34). Finding includes:	F 0688	1. Resident 34 had been assessed by therapy prior with determination for L foot splint. Resident developed a wound and podiatry changed to a L'Nard boot for offloading foot. Wound healed without incident. Therapy to	09/12/2022

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	During an observation, on 08/02/22 at 10:45 a.m., the resident was sitting in his wheel chair, no flexion was noted in his left ankle and the left foot dropped forward. The record for Resident 34 was reviewed on 08/03/22 at 11:40 a.m. Diagnoses included, but were not limited to, Parkinson's disease. No physician's orders were present for therapy, range of motion or treatment. A care plan was not located to address range of motion, therapy or treatment. During an interview, on 08/08/22 at 2:15 p.m., LPN 2 indicated the resident had Parkinson's disease and his mobility had declined. The resident had little mobility to the left ankle and foot. No evaluation had been completed by physical therapy for the left foot. During an interview, on 08/09/22 at 2:30 p.m., the Physical Therapist indicated treatment was started 11/16/21, which included bed mobility, supine to sit, sitting balance, transfer to wheelchair and sit to stand. Physical therapy would be notified if a resident needed an evaluation/screen by nursing staff and with a quarterly evaluation. The resident had not had an evaluation or screen in 2022 according to therapy notes. The therapist did not have documentation of the condition of the left foot. A current policy, titled "Turning and Positioning," dated as revised on 5/11/16 and received from the Director of Health Services (DHS) on 8/9/22 at 5:07 p.m., indicated "...To identify residents who are unable to turn and reposition themselves or those		re-evaluate the resident for potential need of a splint and discuss with resident and family. 2. An assessment of the MDS for residents with any function decline will be completed and residents with a decline will be discussed with MD and referred to therapy for an evaluation if indicated. 3. Staff to be in-serviced to policy on ADL/Mobility and the need to report declines to the MD for therapy evaluations. 4. audits of 5 residents a week for 4 weeks, then 5 residents every other week for 4 weeks, then 5 residents a month for 4 months by the MDS coordinator &/or designee. Residents will be discussed with the nurse, reported to the MD and referred to therapy for an evaluation if indicated. Audit results will be reported in the quarterly QAPI meeting for 6 months. 5. Substantial compliance will be met by 09/12/2022.	

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	requiring assistance to reposition while in bed and assist with turning and repositioning as needed to maintain skin integrity, decreased pain, and maintain proper body alignment...." 3.1-42(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to monitor a post-fall injury for a resident who received an anticoagulant for 1 of 3 residents reviewed for accidents. (Resident 4). Finding includes: During an observation, on 8/1/22 at 12:32 p.m., Resident 4 was sitting up, at the dining table, next to the nurses station. She had a bump on the right side of her forehead about the size of a 50 cent piece in diameter and raised approximately one inch. The record for Resident 4 was reviewed on 8/3/22 at 10:33 a.m. Diagnosis included, but were not limited to, dementia with behavioral disturbance, pulmonary embolism, major depressive disorder, repeated falls and long term use of anticoagulants.	F 0689	1. Resident was assessed and is being followed on weekly skin assessments. 2. skin assessments were completed on all residents who could be affected with findings documented in the resident records, family and MDs notified. 3. Any resident with new skin impairments will have the concern documented in the event system, MD and family notified and follow up assessment to be completed per policy. Clinical staff to be in serviced to the Policy on skin impairments and documentation. 4. Audits of 5 residents a week for 4 weeks, 5 residents every other week for 4 weeks and 5 residents a month for 4 months by the DHS/ADHS and/or designee	09/12/2022

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	A care plan, dated 1/21/21 and revised on 5/10/22, indicated the resident was at a risk for falling related to weakness, confusion, and diagnosis of Parkinson's disease. The goal was for the resident to remain free of falls with major injury. The interventions included, but were not limited to, keep be in the lowest position, mat beside the bed to help prevent injury, staff to assist the resident with transfers as needed and to keep the call light in reach. A care plan, dated 1/21/21, indicated the resident was on a high risk medication and was at risk for excessive bleeding and bruising related to the medication. The interventions included, but were not limited to, notify the physician of abnormal bruising and or bleeding. A physician's order, dated 6/27/22, indicated to give Eliquis (an anticoagulant) 2.5 mg (milligram) twice day. A Fall Report, dated 7/18/22 at 10:30 p.m., indicated there was a scream from the resident's room. The resident was found laying on the floor face down on her stomach with her right arm under her body. The resident was rolled onto her back and a large hematoma was forming to the right side of her forehead. The resident was transferred to the emergency room by the EMTs. A progress note, dated 7/19/22 at 5:15 a.m., indicated the hematoma continued to the right forehead. The progress note did not include measurements of the hematoma. An Event, dated 7/19/22 at 5:19 a.m., indicated the resident had a hematoma to her right forehead and		will be completed. Any findings will be corrected immediately. Audit results will be reported in the quarterly QAPI meeting for 6 months. Substantial compliance will be met by 09/12/2022.	

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	a bruised right shoulder. The resident was on anticoagulant therapy, The Event did not include measurements of the hematoma. A progress note, dated 7/28/22 at 10:57 a.m., indicated the resident continued to have a hematoma to the right side of the forehead on the temple area. The area was about 4 inches in width. The NP was called and notified the area was not healing from the fall. There was a new order for Bactrim DS (an antibiotic) two times a day for 7 days. The progress note on 7/19/22 did not include measurements of the hematoma so it was not known if the 4 inches in width was an increase, decrease or the same. A progress note, dated 7/29/22 at 3:10 p.m., indicated the family had concerns of the hematoma to the right side of the forehead from the previous fall. The NP indicated the hematoma needed to absorb back into the body. There was a new order to discontinue Eliquis (an anticoagulant). There was no measurements of the hematoma on 7/29/22 to indicate if the area was worse or better. During an interview, on 8/5/22 at 2:19 p.m., the Director of Health Services (DHS) indicated there was only one measurement of the hematoma in the electronic health record. The nurse practitioner (NP) indicated the hematoma would be absorbed. If there was no documentation she could not say if the nursing staff did or did not assess the hematoma to see if it was better or worse and she could not determine if the hematoma was better or			

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	worse. The expectation would be for the nurses to follow the policy of documentation. The facility policy did not require the staff to measure bruising or a hematoma. A current policy, titled "Fall Management Program Guidelines," dated a revised 5/31/27 and received from the DHS on 8/5/22, indicated "...Should the resident experience a fall the attending nurse shall complete the 'Fall Event'...Nursing staff will monitor and document continued resident response and effectiveness of interventions for 72 hours...." 3.1-45(a)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that			

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	catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview and record review, the facility failed to assess and document a strong urine odor for 1 of 5 residents reviewed for urinary catheter (Resident 47). Finding includes: During an observation, on 8/1/22 at 3:32 p.m., a strong smell of urine was noted in the resident's room. The resident had a Foley catheter in place with the drainage bag on the side of her bed and it was covered by a cloth dignity bag. During an observation, 8/2/22 at 11:07 a.m., a strong smell of urine was noted in the resident's room. During an observation, 8/8/22 11:45 a.m., the resident was not in the room and there was no urine odor noted. The record for Resident 47 was reviewed on 8/5/22 at 2:34 p.m. Diagnoses included, but were not limited to, hypertensive chronic kidney disease stage 3 and obstructive and reflux uropathy. A progress note, dated 7/8/22, indicated the	F 0690	1. Resident catheter bag was changed, and she was referred to urology to determine alternative treatment options along with adding Vitamin C. 2. All residents with catheters reviewed for appropriate orders and diagnosis for use. 3. Staff in serviced on P&P for foley catheters, medical necessity along with cath care and changes. 4. A random audit of 3 residents with catheters will be completed weekly for 4 weeks for appropriate order and diagnosis, then 3 residents every other week for 4 weeks, then 3 residents monthly for 4 months. The audit results will be reported to the monthly QAPI meeting for 6 months. 5. Substantial compliance will be met by 09/12/2022.	09/12/2022

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	indwelling Foley catheter was inserted. A physician's order, dated 7/11/22, indicated to complete catheter care three times a day and to change the catheter as needed based on clinical observation. During an interview, on 8/8/22 3:38 p.m., CRMA (certified resident medication aide) 5 indicated she had noted strong urine smell in the resident's room. The urine was clear and no leaking from the catheter bag was noted. She was unaware what could be done regarding the strong urine odor. During an observation, on 8/9/22 at 11:50 a.m., the resident was not in the room and a urine odor was not noted. At that time, LPN 2 indicated the strong urine odor was from the catheter bag. The resident came from another facility and the odor was present when she arrived. The bag would be purple in color at times. LPN 2 indicated she did not know how to correct the odor, but would talk to the Nurse Practitioner to get an order for a urinalysis or possibly an acidic flush. A current policy, titled "Urinary Catheter Care," dated as revised 5/11/2016 and received from the Director of Health Services (DHS) on 8/9/22 at 5:10 p.m., indicated "...To prevent infection of the resident's urinary tract...check the urine for unusual appearance...Observe the resident for signs and symptoms of urinary tract infection...Report findings to the charge nurse and/or Director of Health Services...Any changes in character of urine such as color clarity and odor or pain should be reported to the nurse...." 3.1-41(a)(2)			

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F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to date oxygen tubing and humidity bottles for (Resident 157 and D), to administer the correct amount of oxygen as ordered by the physician for (Resident 35) and failed to use the correct route as ordered by the physician for (Resident 22) for 4 of 5 residents reviewed for supplemental oxygen. Findings include: 1. During an observation, on 8/1/22 at 1:37 p.m., Resident 157's oxygen tubing and humidity bottle were not dated and the oxygen concentrator was set a 2 L (liters per minute). The record for Resident 157 was reviewed on 8/3/22 at 4:33 p.m. Diagnoses included, but were not limited to, interstitial pulmonary disease (scarring of the lung tissue), cardiomyopathy (a disease of the heart muscle), anxiety disorder and mood disorder. A physician's order, dated 7/22/22, indicated the resident was to receive 2 liters (2 L/min) of oxygen continuously.	F 0695	1. Oxygen tubing/ bottles and orders were reviewed for accuracy and corrections for residents were made. 2. All residents with oxygen orders were reviewed and tubing changed and dated accordingly along with humidity bottles dated and initialed. Care plans were updated to reflect current orders. 3. Orders were added to change O2 tubing monthly to include concentrators, neb machines and portable O2 tanks. All tubing will be marked with date of change. All humidity bottles will include date changed and initials. Clinical staff educated to policies regarding O2, orders and order timeliness, requirements of changing O2 tubing monthly and ensuring that all are dated and stored in appropriate bags when not in use. 4. Random audits of 5 residents a week for 4 weeks for accuracy will be performed by DHS or designee, then 5 residents every other week	09/12/2022

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	155829	A. BUILDING 00 B. WING	08/09/2022

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	A care plan, dated 8/4/22, indicated the resident was at risk for shortness of breath. Interventions included, but were not limited to, administer oxygen as ordered. During an interview, on 8/1/22 at 1:40 p.m., RN 3 indicated the oxygen tubing and humidity bottle should be dated. 2. During an observation, on 8/1/22 at 1:31 p.m., Resident D's oxygen tubing was not dated and the oxygen concentrator was set at 2 liters. The record for Resident D was reviewed on 8/5/22 at 12:08 p.m. Diagnoses included, but were not limited to, pneumonia, hypertension, depression and anxiety disorder. A physician's order, dated 7/22/22, indicated the resident was to receive 2 liters of oxygen continuously. A care plan, dated 8/1/22, indicated the resident was at risk for shortness of breath. Interventions included, but were not limited to, administer oxygen as ordered. During an interview, on 8/1/22 at 1:40 p.m., RN 3 did not enter the residents room. She indicated if the tubing or humidity bottle did not have a date "I trust you" and walked away. The night shift was supposed to change the tubing and bottles. 3. During an observation, on 8/4/22 at 5:06 p.m., Resident 35 was in the dining room with the portable oxygen tank set on 2 liters. During an observation, on 8/9/22 at 1:45 p.m., the resident was in her room and was not wearing any oxygen.		for 4 weeks, then 5 resident a month for 4 months. All audit findings will be reported at the quarterly QAPI meeting for 6 months. 5. Substantial compliance will be reached by 9/12/2022.	

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The record for Resident 35 was reviewed on 8/5/22 at 9:01 a.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disorder), hypertension, chronic kidney disease, congestive heart failure, cardiac pacemaker and anxiety disorder.

A physician's order, dated 5/6/22, indicated the resident was to receive 4 liters of oxygen continuously.

A care plan, dated 5/9/22, indicated the resident was at risk for respiratory distress. The interventions included, but were not limited to, administer oxygen as ordered.

During an interview, on 8/9/22 at 1:47 p.m., LPN 2 indicated the physician gave her a verbal order a week ago to reduce the oxygen liters and to start weaning the oxygen. She did not enter the order into the electronic health record.

During an interview, on 8/9/22 at 3:24 p.m., the Director of Health Services (DHS) indicated the nurse did not put the verbal order in the computer for the oxygen reduction. 4. During an observation on 8/1/22, the Resident 22 had oxygen to the trach at two liters.

During an observation, on 8/5/22 at 10:53 a.m., the resident was noted to have oxygen at 2 liters per nasal cannula in place.

The record for Resident 22 was reviewed on 8/5/22 at 2:34 p.m. Diagnoses included, but were not limited to, chronic respiratory failure and tracheostomy.

A physician's order, dated 5/18/21, indicated trach

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	oxygen at 2 liters. A physician's order did not include nasal cannula administration. A care plan, dated 5/19/21, indicated the resident had the potential for shortness of breath while lying flat related to asthma and chronic respiratory failure. The approaches included, but were not limited to, administer oxygen per MD order and as needed, trach care as ordered, elevate head of bed or place in upright position as needed. During an interview, on 8/8/22 at 10:00 a.m., the DHS indicated the order had been changed to oxygen two liters per nasal cannula dated 8/6/22. A current policy, titled "Guidelines for Medication Orders," dated 5/2016 and received from the DHS on 8/9/22 at 5:10 p.m., indicated "...To establish the uniform guidelines in the receiving and recording of medication orders...When recording oxygen orders...The rate of flow, route and rationale...." 3.1-47(a)(6)			
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.			

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	§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. Based on observation, interview and record review, the facility failed to have a signed bedrail consent, physician orders and care plan for the side rails for 1 of 1 residents reviewed for accident hazards (Resident 16). Finding includes: During an observation, on 8/1/22 at 3:59 p.m., the resident's bed had two upper side rails. The resident had a contracted left hand. The record for Resident 16 was reviewed on 8/4/22 at 2:47 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the left non dominant side, altered mental status, contracture of left hand, contracture of left elbow and history of falling, The physician's orders did not include the use of side rails. A care plan, dated 10/9/19 and last revised on 6/7/22, indicated the resident had limited range of motion to the left wrist and elbow. The interventions did not include the use of side	F 0700	1. After discussion with resident and daughter, mobility rails were removed from resident bed. 2. All residents were reviewed and audited for the use of mobility rails. Residents that did not meet the guidelines, the mobility rails were removed and the residents that requested to have mobility rails were educated, consents signed, and MD ordered initiated along with Care plan interventions in place. All empty beds were assessed, and mobility bars were removed by Plant Operations. 3. An order is to be placed in TELS when a resident discharges or no longer requires mobility rails to have them removed. Staff educated to use of mobility bars, signed consents, obtaining an MD order, and updating the care plan to reflect the changes. Staff educated when a resident discharges or no longer requires the mobility rails they are to place an order in TELS to have the mobility rails removed from the	09/12/2022

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	rails. A care plan, dated 7/12/19, indicated the resident had an impairment in functional status in regards to bed mobility, transfers, toileting related to weakness, impaired mobility and cardiovascular accident. The interventions included, but were not limited to, the use of Hoyer lift for set up with eating, total assist with transfers, extensive assist with bed mobility and extensive assist with toileting. The interventions did not include the use of side rails. A care plan, dated 7/9/19, indicated the resident was at risk for falling related to weakness, confusion and left side hemiplegia. The interventions included, but were not limited to, monitor resident for proper positioning when in bed, keep personal items within reach, the staff to assist with bed mobility and to utilize a regular mattress on the bed to provide sliding out. The interventions did not include the use of side rails. A Trilogy Bed Rail Informed Consent, dated 7/23/19, indicated the resident had bilateral mobility bars, had medical symptoms which required the assistance with positioning/mobility, had medical symptoms which required the assistance with transfers between positions and the benefits of the rails were functional ability including strength and balance. The risks for the implementation of the rails were accident hazards including, but were not limited to, climbing over, around or between the rails or getting caught between the rails or the mattress. The rails would be used as an enabler. There was no signature on		bed. 4. Random audits of 5 rooms a week for 4 weeks, 5 rooms every other week for 4 weeks and 5 rooms a month by the DHS and/or designee to assess mobility bar use, review of consents, orders, and care plan, if mobility rails. All audits will be reviewed in quarterly QAPI for 6 months. Substantial compliance will be obtained by 9/12/2022	

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	the consent. During an interview, on 8/5/22, the Director of Health Services (DHS) indicated the only side rail consent was dated 2019, the side rail consent was not signed and there was not a physician's order for the side rails. The resident was not able to use his left side at all. A current policy, titled "Guidelines for the Use of Bed Rails," dated 10/9/2017 and received from the DHS on 8/5/22 at 4:05 p.m., indicated "...The facility must attempt to use appropriate alternatives prior to installing a bed rail. If a bed rail is used, the facility us ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements...Bed Rail...full to one-half, one-half, one-quarter, on one-eighth lengths. Examples of bed rail include, but are not limited to...side rails, bed side rails, and safety rails...Grab bars and assist bars...The intent of this requirement is to ensure that prior to the installation of bed rails, the facility has attempted to use alternative...the resident is assessed for bed rails, which includes a review of risks including entrapment; and informed consent is obtained from the resident or if applicable, the resident's representative...The facility should maintain evidence that is has provided sufficient information so that the resident or resident representative could make an informed decision...The use of bed rails as an assistive device should be addressed in the resident's care plan...Informed consent for use of bed rails should be obtained from the resident and/or legal representative...." 3.1-45(a)(1)			

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F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview and record review, the facility failed to dispose of schedule II medications with compromised packaging for 2 of 3 medication carts reviewed (Resident 10 and 23).	F 0755	1. The medication was immediately destroyed by two licensed staff members. 2. All medication cart narcotics	09/12/2022

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	Finding includes: 1. During the 200 hall medication storage observation for medication cart one with CRMA (certified medication aide) 7, on 8/3/22 at 4:42 p.m., there was one card of oxycodone-acetaminophen (an opioid) 7.5 mg (milligram)/325 mg for Resident 10 with the foil torn on tablet #2 and the tablet exposed. During an interview, on 8/3/22 at 4:46 p.m., CRMA 7 indicated she was not sure what to do with the dose of oxycodone-acetaminophen with the torn foil. The record for Resident 10 was reviewed on 8/9/22 at 4:28 p.m. Diagnoses included, but were not limited to, chronic pain, restless leg syndrome, polyneuropathy, migraine, upper abdominal pain and chronic sinusitis. A physician's order, dated 6/14/22, indicated oxycodone-acetaminophen tablet 7.5-325 mg four times daily. 2. During the 200 hall medication storage observation for cart two with LPN 8, on 8/3/22 at 4:55 p.m., there was one card of tramadol (a narcotic pain medication) 50 mg for Resident 23 with the foil torn on dose #9 and the tablet exposed. During an interview, on 8/3/22 at 4:48 p.m., LPN 8 indicated she had to ask the Staff Development nurse what to do with the tramadol tablet with the torn foil. The Staff Development nurse indicated the dose of medication would need to be destroyed.		were audited to ensure that no other concerns were noted. No further findings. 3. Staff to check narcotic medication cards periodically during their shift to ensure there are no rips/tears in the medication foil. If there are concerns, two staff members are to verify, destroy and document regarding the medication that is compromised. Staff were re-educated to medication and narcotic storage and safety practices. 4. audits of all narcotic cards will be completed by the ADHS and/or designee to ensure all narcotics are secure weekly for 4 weeks, then every other week for 4 weeks, then monthly for 4 months. Any findings will be immediately corrected. Audit results will be reviewed during quarterly QAPI meetings for 6 months 5. Substantial compliance will be completed by 9/12/2022.	

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	The record for Resident 23 was reviewed on 8/9/22 at 4:31 p.m. Diagnoses included, but were not limited to, Parkinson's disease, spinal stenosis, pain in the left hip, pain in the right knee and pain in the left foot. A physician's order, dated 6/23/22 and ending 7/23/22, indicated to give tramadol 50 mg six times per day. A current policy, titled "Medication Storage In The Facility," revised on 11/18 and received from the DHS on 8/2/22 at 2:30 p.m., indicated "...Controlled Substance Storage...Medications included in the Drug Enforcement Administration [DEA] classification as controlled substances are subject to special handling, storage disposal and recordkeeping in the facility in accordance with federal, state and other applicable laws and regulations...The Director of Nursing, in collaboration with the Consultant Pharmacist, maintains the facility's compliance with federal and state laws and regulations in the handling of controlled substances. Only authorized medication administration personnel and pharmacy personnel have access to controlled substances...Medications subject to abuse or diversion are stored per state regulation. Alternatively, in a unit dose system, medications may be kept with other medications in the cart if the supply of medication[s] is minimal and a shortage is readily detectable...." 3.1-25(o)			
F 0758 SS=E Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any			

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	drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.			

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	§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to ensure the diagnoses was appropriate for the use of antipsychotic medication, the resident symptoms for the continued use of the antipsychotic medication were documented, gradual dose reductions (GDR) were recommended and addressed timely by the prescriber for 4 of 8 residents reviewed for unnecessary medications (Resident 5, 6, 30 and E). Findings include: 1. The record for Resident 5 was reviewed on 8/5/22 at 11:28 a.m. Diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance, depression and insomnia. A physician's order, dated 9/5/21, indicated Seroquel (an antipsychotic) 12.5 mg (milligram) at bedtime. A physician's order, dated 9/27/21, indicated Seroquel 25 mg twice daily for worsening behavior. A physician's order, dated 1/14/22 through 7/12/22, indicated Seroquel 50 mg twice daily for a diagnosis of dementia with behavioral disturbance. A physician order, dated 7/12/22, indicated Seroquel take 25 mg in the am and 50 mg at bedtime. There was no diagnosis with the physician order	F 0758	1.Resident #5 was reviewed and appropriate dx was associated with resident orders and located in resident records. Res. #6 was reviewed 8/5/22 requested MD 2.All residents on psychotropic medications have the potential to be affected. SSD to be educated on reviewing all psychotropic meds for gradual dose reduction (GDR) needs during behavior meeting. Staff nurses and SSD to be educated on regulatory requirements regarding initiation of GDRs. 3.The DHS and/or designee will audit 5 residents on psychotropic medication, for appropriate initiation of GDR or documentation of clinical rationale if GDR not initiated, weekly for weeks, then every other week for 4 weeks, then monthly for 4 months. 4.As a quality measure, the ED or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. 5. Substantial compliance will be completed by 9/12/2022.	09/12/2022

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	dated 7/12/22. An order set for target behaviors, 8/30/21, indicated to monitor for agitation and aggression and at the end of the shift mark frequency of the behavior and how the resident responded to interventions. The Medication Administration Record (MAR), dated 7/1/22 through 8/5/22, indicated the resident had behaviors of agitation and aggression for 9 out of 70 shifts. The MAR did not include notes on the exact behaviors the resident displayed. The progress notes from 7/1/22 through 8/5/22 did not include any resident behaviors. A Initial Behavior Care Solutions report, dated 7/13/22, indicated the resident had a history of yelling out and resisting care. The assessment and plan indicated the resident had unspecified dementia with behavioral disturbance. The resident had traits concerning for EPS (movement disorder caused by the use of antipsychotic medication). The resident had been on the Seroquel for a year and a GDR would be completed to reduce the chance of side effects, motor issues and increased mortality in the elderly. The lorazepam was also available for as needed agitation and distress. The resident had abnormal movements of the tongue, upper extremities and lower extremities. The report did not include a diagnosis of psychosis, delusions or hallucination. A care plan, dated 2/16/22, indicated the resident demonstrated inappropriate behaviors including			

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	155829	A. BUILDING 00 B. WING	08/09/2022

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	tapping the tables loudly and being disruptive to the environment and yelling out at times. The resident utilized an antipsychotic medication. The goal indicated the resident's behaviors would not result in disruption of others environment. The interventions included, but were not limited to, assess for unmet needs, assist resident to stay away from other residents as needed, determine cause for inappropriate behaviors, encourage participation in structured activities. A care plan, dated 12/14/21, indicated the resident was receiving an antipsychotic medication for aggressive behaviors. The interventions included, but were not limited to, administer medication per physician orders, attempt a GDR in two separate quarters during the first year, attempt to give the lowest dose possible, observe and report signs of extrapyramidal (inability to sit still, involuntary muscle contractions, tremors, involuntary facial movements)symptoms. During an interview, on 8/5/22 at 2:09 p.m., the Director of Health Services (DHS) indicated the resident had agitation and aggression. She would yell out, tap and clap and repeat specific words. She would hit at staff during care. The DHS did not include the resident having any symptoms of delusions, hallucinations or psychosis. The Nursing Drug Handbook, indicated Seroquel had a black box warning and the risk of death was increased in elderly patients with dementia-related psychosis and the drug was not indicated for use in elderly patients with dementia-related psychosis. The drug can cause extrapyramidal signs and symptoms and needs monitored for tardive dyskinesia (causes stiff, jerky movements			

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	of the face and body which can't be controlled). 2. The record for Resident 6 was reviewed on 8/5/22 at 4:23 p.m. Diagnoses included, but were not limited to, encephalopathy, Alzheimer's disease, dementia with behavioral disturbance, anxiety disorder, depression and psychotic disorder with delusions due to known physiological condition. A physician's order, dated 11/1/21, indicated Depakote sprinkles (a mood stabilizer) to give 125 mg once a day. A physician's order, dated 11/1/21, indicated to give Depakote sprinkles 250 mg at bedtime. A physician's order, dated 4/6/22, indicated to give Seroquel 25 mg twice a day. A target behavior set, dated 8/10/21, indicated to monitor each shift for aggression, grabbing, hitting and document frequency and how the resident responded to redirection. A target behavior set, dated 8/10/21, indicated to monitor for anxiety, restlessness and irritability each shift and document frequency and response to redirection. During an interview, on 8/9/22 at 5:06 p.m., the DHS indicated the original order for the Depakote (mood stabilizer) was dated 7/2/21. A care plan, dated 1/21/22 and revised on 5/9/22, indicated the resident at times refused care, yelled out and cried. The interventions included, but were not limited to, observe and document changes in mood, behaviors and pain, offer phone call to family, as needed pain medication as			

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	ordered, attempt care at a later time. A care plan, dated 8/10/21 and last revised on 5/9/22, indicated the resident demonstrated physically abusive and resistive behaviors toward staff during hands on care with grabbing and hitting. The interventions included, but were not limited to, approach resident in a calm and unhurried manner to deliver care and provide services, explain process prior to delivery of care, observe for signs of sensory overstimulation and offer choices in hands on care. A care plan, dated 8/6/21 and last revised on 5/9/22, indicated the resident was at risk for adverse consequences related to receiving antipsychotic medication. The interventions, included, but were not limited to, administer medication per physician's orders, attempt GDR in two separate quarters, unless contraindicated, attempt to give the lowest dose possible. During an interview, on 8/9/22 at 3:02 p.m., the DHS indicated the GDR request from the pharmacy for Seroquel, dated 2/9/22, was not addressed by the nurse practitioner (NP) until 3/2/22. The Seroquel was decreased on 3/2/22 and then the resident had behaviors of throwing cookies and threatened to call the police so the Seroquel was a failed GDR and increased again. There was no GDR on the Depakote. She was not sure why it took from 2/9/22 until 3/2/22 for the NP to address the GDR for the Seroquel. The Seroquel and the Depakote were prescribed for the dementia with aggressive behaviors. During an interview, on 8/9/22 at 3:19 p.m., the DHS indicated there was no GDR requested for Depakote and only one request for a GDR for the Seroquel. The Seroquel should have had the			

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	diagnosis of psychotic disorder due to known delusions and the Depakote did not have a diagnosis related to it. 3. The record for Resident 30 was reviewed on 8/3/22 at 3:22 p.m. Diagnoses included, but were not limited to, major depressive disorder, anxiety disorder, cerebral infarction, renal dialysis and chronic pain. A physician's order, dated 11/18/21, indicated escitalopram 20 mg once a day for depression. A pharmacy recommendation, dated 2/9/21, indicated the resident had the following medications due for evaluation an order for escitalopram (an antidepressant) 20 mg daily and diazepam 1 mg every morning, 2 mg every evening and 2 mg at bedtime. The recommendation was to decrease the diazepam. The NP addressed the diazepam and did not respond to the recommendation for the escitalopram. During an interview, on 8/9/22 at 4:30 p.m., the DHS indicated the resident did not have a GDR for the escitalopram in the electronic health record.4. The record for Resident E was reviewed on 08/03/22 at 12:06 p.m. Diagnoses included, but were not limited to, positive Covid-19, encephalopathy (damage or disease affecting the brain), dementia without behavioral disturbance, cerebral infarction and anxiety disorder. A physician's order, dated 06/30/22, indicated to give olanzapine (an antipsychotic medication) 5 mg (milligrams) one tablet at bedtime for a diagnosis of encephalopathy.			

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	A care plan, dated 07/12/22, indicated the resident was at risk for adverse consequences related to receiving an antipsychotic medication for a diagnosis of acute encephalopathy. Interventions included, but were not limited to, pharmacy consultant review as needed. An order set for target behaviors, dated 07/30/22, indicated to monitor for hallucinations, delusions, etc. twice a day. The MAR, dated between 07/30/22 and 08/05/22, indicated the only behavior was on 07/30/22. The type of behavior was not indicated on the MAR. A facility form, titled "Trilogy - Pharmacy Recommendation," dated 07/27/22, indicated the resident was taking olanzapine with a diagnoses encephalopathy. The resident lacked an allowable diagnoses to support its use. The pharmacist recommended the facility to note the appropriate diagnosis. If an appropriate diagnosis did not exist, the facility should consider a reduction to begin tapering off the medication. During an interview, on 08/05/22 at 2:09 p.m., the DHS indicated she witnessed the resident having hallucinations. Resident E would say her son was walking down the hall. The son was not even there. The DHS also indicated her son would visit often. These issues did not cause the resident any distress. The Nursing Drug Handbook, indicated olanzapine had a black box warning to include the medication may increase the risk of cardiovascular or infection related death in elderly patients and was not appeared to treat patients with dementia related psychosis.			

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	A current policy, titled "Psychotropic Medication Usage and Gradual Dose Reduction," revised 10/09/17 and received from the DHS on 08/09/22 at 5:08 p.m., indicated "...To ensure effort is made for residents receiving psychoactive medications to obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team...Residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record and in the care planning process...Regular monthly review of antipsychotics in CAR for continued need, appropriate dosage, side effects, risks and/or benefits will be conducted, to ensure the use of psychopharmacological medications are therapeutic and remain beneficial to the resident...A gradual dose reduction (GDR) will be attempted for two (2) separate quarters (with at least one month between attempts)...Gradual dose reduction must be attempted annually thereafter, unless medically contraindicated...." 3.1-48(a)(2) 3.1-48(a)(4)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals			

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	§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure medications brought in from an outside source were labeled for 1 of 3 medication carts reviewed (Resident 7). Finding includes: During an observation, on 8/3/22 at 4:42 p.m., the medication cart one on the 200 hall had one box or omeprazole (a medication to treat heartburn, stomach ulcers and gastroesophageal reflux) 20 mg (milligram) delayed release with 14 tablets. The box did not have label with directions and did not have a resident name on it. During an interview, on 8/3/22 at 4:44 p.m., CRMA (certified resident medication assistant) 7 indicated the omeprazole belonged to Resident 7. The staff had labels from the pharmacy to put on medication which were not labeled. The record for Resident 7 was reviewed on 8/10/22	F 0761	1. Medication listed was immediately identified and the box was labeled accordingly with the correct resident information. 2. All medication carts and storage areas were assessed for unlabeled medications. No other medications were found. 3. Staff re-inserviced to label any medications received from outside providers or families with the OTC labels provided by pharmacy. 4. A random audit of each medication cart weekly for 4 weeks, then every other week for 4 weeks, then monthly for 4 months by the DHS/ADHS or designee will be completed for unlabeled medications. The results of the audits will be reviewed during the quarterly QAPI meetings for 6 months.	09/12/2022

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	at 4:30 p.m. Diagnoses included, but were not limited to, gastritis, gastroesophageal reflux disease and diaphragmatic hernia. A physician's order, dated 2/27/22, indicated to give omeprazole 20 mg, two tablets in the g-tube twice daily. A care plan, dated 4/12/22, indicated the resident was at risk for chest and stomach pain and burning related to the diagnoses of gastroesophageal reflux and gastritis. The interventions included, but were not limited to, administer medication as ordered by the physician. A current policy, titled "Medication Storage In The Facility," revised 1/17 and received from the Director of Health Services (DHS) on 8/4/22 at 12:20 p.m., indicated "...Medications and biologicals are stored safely, securely, and properly, following manufacture's recommendations or those of the supplier...The provider pharmacy dispenses medications in containers that meet regulatory requirements, including standards set forth by the United States Pharmacopoeia[USP]...Medications are kept in those containers...All medications dispensed by the pharmacy are stored in the container with the pharmacy label...Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart..." A current policy, titled Medication Ordering and Receiving From Pharmacy," revised on 1/17 and received from the DHS on 8/4/22 at 12:20 p.m., indicated "...Medications brought into the facility by a resident or responsible party are used only upon written order by the resident's attending		5. Substantial compliance will be reached by 9/12/2022	

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	physician, after the contents are verified, and if the packaging meets the facility's guidelines. Unauthorized medications are not accepted by the facility...Use of medications brought to the facility by a resident or responsible party is allowed only when the following conditions are met...The medication name, dosage form, and strength have been verified by...consulting a tablet identification reference...The medication was ordered by the resident's physician and entered in the resident's medical record...The medication container is clearly labeled in accordance with the facility procedures for medication labeling and packaged in a manner consistent with facility guidelines for medications...Medications not ordered by the resident's physician, or unacceptable for other reasons, are returned to the responsible party or designated agent...." A current policy, titled "Medication Storage In The Facility," revised on 01/17 and received from the DHS on 8/4/22 at 12:20 p.m., indicated "...Storage of Medications....Medications and biologicals are stored safely, securely, and properly, following manufacture's recommendations or those of the supplier. The medication supply is accessible only to licensed facility personnel, pharmacy personnel, or staff members lawfully authorized to administer medications...Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal...." 3.1-25(j)			
F 0921 SS=D	483.90(i) Safe/Functional/Sanitary/Comfortable Environ			

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Bldg. 00	§483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure the walls in a resident's room had been painted for 1 of 24 rooms reviewed for environment (Resident 30). Finding includes: During an observation, 8/1/22 at 3:46 p.m., Resident 30's room had a large area of exposed drywall plaster which extended from the middle of the wall to the floor which covered about 50% of the wall. There were also areas of exposed drywall on the wall next to the bathroom and gouges in the door. During an interview, on 8/8/22 at 2:14 p.m., Resident 30 indicated the facility staff had been talking about the patches of drywall in her room for the last 5-6 months. The previous maintenance staff told her they could not repair the walls because she would make new holes in them. The new maintenance staff told her the painting of the walls were on his list of items to do. A Resident Council meeting note, dated 9/17/21, indicated Resident 30's room had still not been painted. During an interview, on 8/8/22 at 2:28 p.m., the Administrator indicated he was aware of Resident 30's room needing painted along with one other room. He indicated the room had been painted before and it gets beat up. The resident in the room utilized an electric wheelchair and the chair was causing the issues with the walls. The facility had a change in maintenance staff and he would	F 0921	1. The affected room was completed and painted by the Plant Operations immediately. 2. Plant Operations and ED will inspect all resident rooms for need of repairs and schedule needed repairs in TELS to be completed timely. 3. Education provided to Plant operations regarding policy and regulation for residents living in comfortable environment. 4. The ED and/or designee will do random audits of 5 rooms per week for 4 weeks, then 5 rooms every other week for 4 weeks, then 5 rooms a month for 4 months to ensure there are no resident rooms in need of repairs. All resident concerns with repairs will be logged into the TELS system and assigned to be completed. The ED or designee will follow up with the Plant Operations on completions or delays to ensure needed repairs are completed timely. Findings will be reviewed in Quarterly QAPI meetings. 5. Substantial compliance will be reached by 9/12/2022	09/12/2022

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	talk to the previous staff to find out the status of the paint for the walls. During an interview, on 8/8/22 at 4:57 p.m., the Administrator indicated he had talked with the previous maintenance staff and the staff indicated he did not paint the resident's room since she had knocked out some of the drywall patchwork with her electric chair and he gave up. A current policy, titled "Walls, Preventative Maintenance," revised on 2/8/2018 and received from the Director of Health Services (DHS) on 8/9/22 at 5:10 p.m., indicated "...It is Trilogy policy to inspect common area and corridor walls monthly. [Resident room walls are inspected during routine semi-annual preventative maintenance]...Inspect walls monthly based on the master preventative Maintenance Schedule...Survey the walls for any paint or wallcovering that needs repairs...Touch up painting requires painting walls from break point to break point. Touching up spots on the walls is not an acceptable practice...." 3.1-19(f)(5)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Nursing Home Complaints IN00372237 and IN00369472. Complaint IN00372237 - Substantiated. Federal/State deficiencies related to the allegations are cited at F550.	R 0000	The submission of this plan of correction does not indicate an admission by The Springs at Lafayette Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of The Springs at	

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	Complaint IN00369472 - Substantiated. Federal/State deficiencie related to the allegations are cited at F676. Survey dates: August 1, 2, 3, 4, 5, 8 and 9, 2022. Facility number: 013499 Residential Census: 29 The Springs at Lafayette was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review was completed on August 17, 2022.		Lafayette Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	