STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155286	A. BUILDING 00 B. WING	01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AVALON VILLAGE	200 KINGSTON CIR LIGONIER, IN 46767

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00396009. Complaint IN00396009- Substantiated. Federal/State deficiencies related to the allegations are cited at F725. Survey dates: January 22, 23, 24, 25, and 26, 2023 Facility number: 000184 Provider number: 155286 AIM number: 100267210 Census Bed Type: SNF/NF: 50 Total: 50 Census Payor Type: Medicare: 5 Medicaid: 42 Other: 3 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 30, 2023	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance Requesting Desk Review	
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.			

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

Jessica Slone | Executive Director | 02/23/2023

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

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	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, record review, and interview, the facility failed to ensure the resident's right to a dignified existence in 3 of 5 residents reviewed for dignity. (Resident 207, Resident 27 and Resident 41)	F 0550	REQUESTING DESK REVIEW F550 Resident Rights 1. Residents 27,41 and 207 were immediately assessed to ensure skin was not exposed and	02/23/2023

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	Findings include: 1. During an observation on 1/22/23 at 10:54 AM, Resident 27 was observed laying in bed with one breast and the left side of the body exposed. During an observation on 1/22/23 at 2:21 PM, Resident 27 was observed laying in bed with her dress pulled up over her waist, her incontinence pad was visible, and her bare left leg and abdomen was visible from the doorway. On 1/24/23 at 11:42 AM, Resident 27 record was reviewed. Diagnoses included metabolic encephalopathy, morbid obesity, acute on chronic diastolic congestive heart failure, essential hypertension, fluid overload, chronic cor pulmonale, atrial flutter, chronic obstructive pulmonary disease, permanent atrial fibrillation, ventricular tachycardia, chronic respiratory failure with hypercapnia, respiratory failure hypoxia or hypercapnia, and shortness of breath. Resident 27's quarterly Minimum Data Sheet (MDS) assessment, dated 12/22/22, indicated the resident's Brief interview for Mental Status (BIMS) score was 2, she was not oriented and not interviewable. The MDS indicated she was required 2 plus physical assistance for bed mobility, transfer, dressing, toileting and bathing. Resident 27's care plan, last revised 12/30/22, was reviewed. On 9/27/22, a care plan problem indicated the resident required assistance with activities of daily living (ADLs) including bed mobility, transfers, eating, and toileting with a goal target date of 1/2/23 indicating the resident had a desire to improve her current functional level. An approach, dated 9/27/22, indicated		that resident rights and dignity were in place. Resident 41 was provided bigger clothes and will be working with OT on dressing. Residents 27 and 207 were offered personal choice of clothing and careplans were updated. 2. There were no other residents affected by this practice. All other residents were assessed by staff to ensure clothing fit appropriately and skin was not exposed. Residents who prefer to wear a gown have careplans that accurately reflect this preference. 3. Staff educated by the Social Services Director on dignity, resident rights, skin exposure, and preferred clothing. Residents will be reviewed by IDT upon admission, and with careplan reviews to ensure resident still has proper fitting clothing and preferences are updated. Frequent rounds will be completed to ensure residents have a dignified existence, not exposed, proper fitting clothing and hospital gowns are appropriately covering the resident. 4. To ensure compliance, SSD or Designee is responsible for completing the resident rights/Dignity CQI audit tool weekly times 4 weeks then every 2 weeks times 4 weeks then monthly for at least 6 months. The form will be reviewed during facility	

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	nursing would assist with dressing/grooming/hygiene as needed. On 9/27/22, a care plan problem indicated the resident required assistance and monitoring with AM/PM care, nutrition, hydration, and elimination with a goal target date of 1/2/23 to indicate the resident would have ADL needs met. 2. During an observation on 1/23/23 at 1:34 PM, Resident 41 was observed with pants covering the tops of his thighs, but his buttocks were exposed. Resident 41's shirt was bunched above his navel and his lower abdomen was also exposed. During an interview with Resident 41, he indicated his pants didn't fit well and placed a small quilt on his lap covering part of his lower abdomen, pelvis and upper thighs. During an observation on 1/26/23 at 10:15 AM, Resident 41 was observed in the therapy gym through a large window in a main corridor of the facility. Resident 41's shirt was bunched above his navel with his lower abdomen exposed. Resident 41's pants were covering his pelvic area and his upper thighs. His right buttock was exposed and visible from the hallway. During an interview and observation on 1/26/23 at 11:03 AM, Certified Nursing Assistant (CNA) 2 indicated Resident 41's buttock was exposed, but should not be exposed. CNA 2 indicated Resident 41 normally dressed himself with set up assistance and probably needed more staff assistance with dressing. During a record review conducted on 1/26/23 at 11:10 AM, Resident 41 had diagnoses including rhabdomyolysis, type 2 diabetes mellitus, chronic kidney disease, stage 2, and muscle weakness. A Minimum Data Set (MDS) dated 11/18/22		CQI meeting. If 100% threshold is not achieved an action plan will be developed. 5. Completion date: 2/23/23	

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	indicated Resident 41 had a Basic Interview for Mental Status (BIMS) score of 12, indicated some cognitive impairment. The MDS indicated Resident 41 received extensive assistance with dressing tasks. A care plan dated 10/24/21 indicated Resident 41 should have been assisted as needed with dressing tasks. No care plan regarding refusal of assistance with dressing tasks was available for review. No progress notes regarding refusal of assistance with dressing tasks was available for review. 3. During an observation on 1/22/23 at 10:48 AM, Resident 207 was sitting in a recliner in a lounge area near the nurse's station with other residents seated near her. Resident 207 was wearing a hospital gown that was untied in the back. Her chest area including her right breast was exposed. She was leaning forward with her back and right side of her body including her right leg visible. Registered Nurse (RN) 4 was observed walking past Resident 207 several times. RN 4 did not interact with her or make any attempt to assist her in covering exposed areas. During an observation on 1/22/23 at 1:45 PM, Resident 207 was sitting in a recliner in the lounge area near the nurse's station. Resident 207 was wearing a hospital gown. The gown was untied and draped over part of her body. Resident 207's upper body including her right breast was exposed. Resident 207 had a blanket covering her left leg and pelvis. Her right leg and right side of her abdomen were exposed. RN 4 and RN 5 were seated in the nurse's station within view of Resident 207, but did not approach Resident 207.			

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	A record review on 1/24/23 at 2:26 PM, indicated Resident 207 had diagnoses including hyperlipidemia, hypertension, and unspecified dementia without behavioral disturbance. An MDS dated 12/25/22 contained a BIMS score of 4 indicating severe cognitive impairment and inability to be interviewed. A review of Resident 207's care plan dated 1/22/23 related to dignity indicated an intervention of: Offer alternative clothing options. Resident 207 was observed on a hospital gown on 1/22/23 at 10:48 AM, 1/23/23 at 1:45 PM, and 1/24/23 at 10:54 AM. In an interview on 1/24/23 at 1:33 PM, Resident 207's family member indicated she comes into the facility at times to witness the resident in a hospital gown. She indicated no alternative clothing choice had been discussed with her. During an interview with on 1/26/23 at 1:19 PM, the DON indicated breasts and genitalia should be covered, but she was unsure if any other body parts should be covered while in the presence of others. During an interview on 1/26/23 at 1:33 PM, the Social Services Director indicated there was no specific facility policy pertaining to exposure of body parts. She indicated the facility follows the document titled Resident Rights: Know Your Rights under Federal Nursing Home Regulations dated 3/15/17. This document indicated residents have the right to a dignified existence. 3.1-3(a)			

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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 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, record review and interview, the facility failed to ensure a resident	F 0690	REQUESTING DESK REVIEW F690 Bowel/Bladder Incontinence, Catheter, UTI	02/23/2023

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	care plan was developed and implemented for 1 of 1 resident reviewed with nephrostomy tubes. (Resident 6). Finding include: During an observation on 1/22/23 at 11:52 AM, Resident 6 was observed laying in her bed. There was a drainage bag on each side of her body. On 01/25/23 at 3:08 PM, Resident 6's record was reviewed. Diagnoses included neuromuscular dysfunction of bladder with urinary tract bilateral nephrostomy tubes, history of malignant neoplasm of cervix uteri, and a vesicointestinal fistula. Resident 6's quarterly Minimum Data Set (MDS), dated 12/21/22, indicated the resident's Brief Interview for Mental Status (BIMS) score was 15, she was alert, oriented and interviewable. The MDS assessment indicated the resident had an indwelling catheter (including suprapubic and nephrostomy tube). In an interview on 1/26/23 at 4:05 PM, the Director of Nursing (DON) indicated in January 2022 the resident had her urinary catheter replaced by the bilateral nephrostomy tubes. She indicated the staff followed care plans to ensure proper care was being given. A review of the resident's orders, dated 3/14/22 and 7/29/22 respectively, indicated the nephrostomy tubes were to be instilled directly with 10cc of NS (do not pull back and allow to drain by gravity once a day) and change the nephrostomy bag daily, were both PRN (as needed). A new physician's order dated 1/23/23 indicated Resident 6's nephrostomy bags were to		1. 1. The careplan for the resident # 6 was immediately updated to reflect nephrostomy tubes. 2. 2. All other residents have the potential to be affected by this practice. All residents were reviewed to ensure careplans accurately reflect plan of care. 3. 3. Staff educated by the Director of Nursing on developing and implementing a careplan and following a careplan. Residents will be reviewed by IDT members upon admission review, significant changes, quarterly MDS assessments, and after physician visits to ensure careplans will be updated with any changes. 4. 4. To ensure compliance, the DNS or Designee is responsible for completing the CQI care plan audit tool weekly times 4 weeks then every 2 weeks times 4 weeks then monthly for at least 6 months. The form will be reviewed during facility CQI meeting. If 100% threshold is not achieved an action plan will be developed. 5. Competion date: 2/23/23	

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	be changed daily on the 14th of the month, the nephrostomy tubes were to be instilled with 10 cubic centimeters (cc) of normal saline (NS) once a day with drainage to gravity and output recorded every shift. A review of Resident 6's Treatment Administration Record (TAR) indicated the nephrostomy bags were changed on 1/14/23, the nephrostomy tubes were instilled with 10 cubic centimeters (cc) of normal saline (NS) once a day with drainage to gravity and output was recorded every shift from 1/1/23 to 1/23/23. There was no documentation to the TAR for PRN use. A review of Resident 6's care plan, last revised 12/21/22, did not indicate the residnet was to have nephrostomy care. In an interview on 1/26/23 at 2:43 PM, the Administrator indicated she was uncertain if a care plan was needed for Resident 26's nephrostomy care and spoke with the Corporate MDS coordinator. The administrator indicated the Corporate MDS coordinator would investigate. No response from the administrator was provided by survey exit. In an interview on 1/26/23 at 4:05 PM, the DON indicated Resident 6's urinary catheter was care planned until January 2022 when replaced by bilateral nephrostomy tubes, but no care plan had been developed for the resident's nephrostomy care. On 1/26/23 at 2:25 PM, a current policy titled "American Senior Communities IDT Comprehensive Care Plan Policy", revised 10/2019, provided by the DON, indicated each resident would have a comprehensive			

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	person-centered care plan developed based on their comprehensive assessment and the care plan would include measurable goals. The resident's care plan would include specific interventions based on the resident needs to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial needs. 3.1-41(a)(2)			
F 0695 SS=D 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, record review and interview, the facility failed to ensure residents received appropriate oxygen therapy for 2 of 4 residents reviewed with respiratory care. (Resident 25 and Resident 27). Findings include: 1) On 1/22/23 at 2:23 PM, Resident 25's record was reviewed. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypercapnia, respiratory failure hypoxia or hypercapnia, acute on chronic diastolic congestive heart failure, essential hypertension, fluid overload, atherosclerosis of the coronary bypass graft(s) without angina pectoris, diabetes mellitus without complications,	F 0695	REQUESTING DESK REVIEW F 695 Respiratory/Tracheostomy Care and Suctioning 1. 1. Oxygen orders for resident 25 and 27 were clarified with the physician. Physician orders are accurate and in place. 2. 2. All other residents have the potential to be affected by this practice. All residents with oxygen orders were reviewed to ensure orders and careplans accurately reflect the plan of care. Rounding has been completed by the DNS to ensure plan of care is in place and orders are accurate. 3. 3. Staff educated by the	02/23/2023

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	obstructive sleep apnea, chronic cor pulmonale, atrial flutter, atherosclerosis of the aorta, morbid obesity, permanent atrial fibrillation, ventricular tachycardia, metabolic encephalopathy, and shortness of breath. Resident 25's quarterly Minimum Data Set (MDS) assessment, dated 12/22/22, indicated the resident's Brief Interview for Mental Status (BIMS) score was 2 and she was not interviewable. The resident's MDS did not indicate she wore oxygen. During an observation on 1/22/23 at 2:23 PM, Resident 25 was observed laying in her bed with oxygen at 5 liters per minute (LPM) on nasal cannula (tubing used to deliver oxygen through the nostrils) via concentrator (a machine used to produce oxygen). In an interview on 1/22/23 at 2:23 PM, the Director of Nursing (DON) indicated Resident 25's oxygen flow rate was set at 5 liters per minute. A review of the Resident 25's's orders, dated 9/27/22, indicated she was to receive oxygen at 3 LPM per nasal cannula (NC) every shift, oxygen tubing/humidity to be changed and concentrator and filter cleaned once a day on Sunday and oxygen saturations checked every shift. On 1/22/23 at 2:44 PM an order indicated to discontinue the order for oxygen at 3 LPM per NC and to give oxygen at 4.5 LPM per NC with special instructions: may titrate to keep saturations above 90% for respiratory failure every shift . A review of Resident 25's Treatment Administration Record (TAR) indicated her oxygen was documented at 3 LPM per NC every shift from 1/1/23 to 1/22/23 2:00 PM -10:00 PM.		Director of Nursing on obtaining and following physician orders for all residents on oxygen. Residents will be reviewed by IDT members upon admission review, significant changes, quarterly MDS assessments, and after physician visits to ensure orders are updated with any changes. DNS/Designee will round each day to ensure oxygen flow is per physician order. 4. 4. To ensure compliance, the DNS or Designee is responsible for completing the CQI respiratory audit tool weekly times 4 weeks then every 2 weeks times 4 weeks then monthly for at least 6 months. The form will be reviewed during facility CQI meeting. If 100% threshold is not achieved an action plan will be developed. 5. 5. Completion date: 2/23/23	

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	The TAR indicated oxygen tubing/humidity was changed and concentrator and filter cleaned on Sunday 1/1/23, 1/8/23, 1/15/23, 1/22/23, 12/4/22, 12/11/22, 12/18/22, 12/25/22, 11//6/22, 11/13/22, 11/20/22, and 11/26/22. The TAR indicated oxygen was documented to be given at 4.5 LPM per NC every shift from 1/22/23 2:00 PM - 10:00 PM to 1/23/23. There was no Respiratory Treatment Record for Resident 25. A review of Resident 25's care plan, dated 12/7/22, indicated the resident was at risk for ineffective tissue perfusion and the goal was she should maintain adequate tissue perfusion. One approach to reducing this risk per the care plan indicated nursing would observe and document signs of pallor, cyanosis, dizziness, syncope, shortness of breath, bounding/thready pulse, headache, variations in blood pressure, abnormal lung sounds, abnormal oxygen saturations and notify the medical doctor. In an interview on 1/22/23 at 2:37 PM, RN 4 indicated Resident 25's oxygen liter flow rate was on 4.5 LPM since last weekend because the resident needed more oxygen and staff had continued with the 4.5 LPM; this information was passed on to her shift report. RN 4 indicated she was aware of the order for oxygen at 3 LPM and indicated it was increased as a "nursing measure". A review of the resident's Vitals Record, dated 1/1/23 to 1/21/23, indicated Resident 25's oxygen flow rate was above 3 liters (from 4 LPM to 4.5 LPM) in 31 of 80 records. Resident 25's Vital Record, dated 1/14/23 at 9:04 PM, indicated the resident's oxygen flow rate was set on 3 liters and her oxygen saturation was 98%. Resident 25's flow rate was increased to 4 liters that evening at 8:24 PM, her oxygen saturation was 96%, and the			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident's oxygen flow remained at or above 4 liters in 19 of 39 records reviewed through 1/21/22. Resident 25's Vitals Report dated 1/1/23 to 1/21/23 indicated the resident's oxygen saturation ranged from 90% to 98%. A review of the progress notes, dated 1/1/23 to 1/21/22, indicated no notifications to the medical doctor regarding Resident 25's oxygenation status. 2) On 01/22/23 at 1:13 PM, Resident 27's record was reviewed. Diagnoses included COPD, chronic respiratory failure with hypoxia, supraventricular tachycardia, chronic systolic congestive heart failure, cerebral infarct due to thrombosis of right middle cerebral artery, spastic hemiplegia and hemiparesis affect left side non-dominant side, old myocardial infarction, and history of Covid19. Resident 27's quarterly MDS assessment, dated 10/19/22, indicated the resident's BIMS score was 13, he was alert, oriented and interviewable. The MDS indicated he wore oxygen prior to arrival at the facility and continued to wear oxygen at the facility. During an observation on 1/22/23 at 1:13 PM, Resident 27 was observed laying in his bed with oxygen at 3 LPM per NC via a concentrator. A review of Resident 27's orders, dated 3/6/19, indicated the resident's oxygen saturations were to be checked every shift. On 4/4/19, an order indicated the resident was to be on oxygen at 2 LPM per NC every shift. On 12/12/19, an order indicated to change oxygen tubing and humidity once a day on Sunday. On 1/22/23 at 3:40 PM, an order indicated to discontinue the order, dated			

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	155286	A. BUILDING 00 B. WING	01/26/2023

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	4/4/19, for oxygen at 2 LPM per NC. Thewre was no reason indicated discontinue the order. An oxygen order, dated 1/22/23, indicated to give Oxygen at 3 LPM per NC with special instructions: may titrate to keep saturations above 90% for COPD every shift. A review of Resident 27's Respiratory Administration Record (RAR) indicated oxygen saturations were documented every shift in November, December and 1/1/23 to 1/23/23. The RAR indicated the oxygen was documented at 2 LPM per NC every shift 1/1/23 to 1/22/23 10:00 PM -6:00 AM. The RAR indicated oxygen tubing and humidity was changed on Sunday 1/1/23, 1/8/23, 1/15/23, 1/22/23, 12/4/22, 12/11/22, 12/18/22, 12/25/22, 11/6/22, 11/13/22, 11/20/22, and 11/26/22. The RAR indicated the oxygen was documented at 3 LPM NC on 1/22/23 2:00 - 6:00 AM to 1/24/23 6:00 AM - 2:00 PM. A review of Resident 27's care plan, dated 11/9/22, indicated the resident was at risk for ineffective tissue perfusion and should maintain adequate tissue perfusion. One approach, dated 3/6/19, indicated nursing would observe and document signs of pallor, cyanosis, dizziness, syncope, shortness of breath, bounding/thready pulse, headache, variations in blood pressure, abnormal lung sounds, abnormal oxygen saturations and notify the medical doctor. A review of the resident's Vital Record, dated 1/1/23 to 1/21/22, indicated Resident 27's oxygen flow rate was above 2 LPM (at 3 LPM) in 23 of 63 records. Resident 25's Vitals Report, dated 1/1/23 to 1/21/23, indicated the resident oxygen saturation ranged from 94% to 97%. In an interview on 1/22/23 at 2:37 PM, RN 4			

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	indicated a low oxygen reading would be below 90%. In an interview on 1/26/23 at 1:21 PM, the DON indicated she had a discussion with MD 3. She indicated he indicated the nurses knew what he wanted for oxygen therapy and they could adjust oxygen as they like, it was a verbal policy. The DON indicated there is no written policy or protocol. On 1/23/23 at 10:38, an information sheet titled "SMS Specialized Medical Services Oxygen Therapy and Devices", undated, provided by the DON, indicated oxygen is a drug which must be ordered by a physician. An information sheet titled "SMS Specialized Medical Services Oxygen Concentrator", undated, indicated when an oxygen concentrator is used the physician's order must be verified and understood, must know the flow rate and duration of use, and the flow meter control must be adjusted to the flow setting prescribed by the physician where the graduated line of the meter should align with the center of the floating ball. No facility policy for oxygen administration was provided by survey exit. 3.1-47 (a)(4)			
F 0725 SS=F Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and			

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	considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview, and record review, the facility failed to ensure adequate staff were present to meet the physical needs of the residents. 50 residents resided in the building. During the initial tour of the building on 1/22/23 beginning at 10:47 AM, food trays from the breakfast meal were observed in rooms 305, 309, 313 and 314. Resident B was observed sitting in a recliner in the lounge area wearing a hospital gown that was not tied in the back. The gown was hanging down in the front exposing most of her chest, including her right breast. Registered Nurse 4 was observed walking past Resident B several times. RN4 made no attempt to interact with her or assist with covering her exposed areas. Resident C was observed from the hallway outside her door partially covered with a gown. Resident C's left side of her body, including her left breast, was exposed and visible from the	F 0725	REQUESTING DESK REVIEW F 725 Sufficient Nursing Staff 1. 1. Residents in question were immediately assessed by staff to ensure there are no immediate needs that need addressed. 2. 2. All other residents have the potential to be affected by this practice. Rounds were completed on all residents to ensure care is provided per plan of care. 3. 3. Staff educated by the Director of Nursing on removing hall trays, answering call lights, dignity/resident rights, providing showers and toileting schedules. Staffing levels were reviewed by the Executive Director to ensure adequate staffing to meet the needs of the residents. Additional	02/23/2023

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	hallway. In an observation on 1/22/23, the call light in room 312 was on from 11:25 AM to 11:42 AM. Resident D moved from a lying to seated position with her legs over the side of the bed and indicated she needed to go to the bathroom. Resident D was identified as cognitively impaired and not interviewable by facility staff. In an observation on 1/24/23, the call light in room 308 was on from 9:01 AM to 9:18 AM. Resident E was overheard to indicate if someone did not come to help her, she would get up and take herself to the bathroom. In an interview on 1/24/23 at 10:45 AM, Resident E, identified as alert and interviewable by facility staff, indicated there was sometimes not enough staff to ensure she got the bathroom when she needed to go. During an interview on 1/23/23 at 10:12 AM, Resident F, identified as alert and interviewable by facility staff, indicated staff frequently did not have time to give her a shower when scheduled and it was only rarely offered the next day if it was missed. During an interview on 1/22/23 at 11:45 AM, Resident G, identified as alert and interviewable by facility staff indicated she had to lie in urine and bowel movement for 9.5 hours. She indicated that she used her call light several times to ask for assistance and was told staff did not have time but would return to her later. During an interview on 1/23/23 at 10:06 AM, Resident H, identified as alert and interviewable by facility staff, indicated concerns about call		nurse agency contracts have been secured by the Executive Director to assist with staffing needs. The Executive Director will review resident council forms to ensure any concerns with care or staffing are addressed. Staffing agencies will be utilized as needed to ensure care is being completed. Nurse aide in Training program is monitored by the Executive Director and students will be entered into the next available class after hire. 4. 4. To ensure compliance, the DNS or Designee is responsible for completing the CQI rounds audit tool and call light audit weekly times 4 weeks then every 2 weeks times 4 weeks then monthly for at least 6 months. SSD or Designee is responsible for completing the resident rights/Dignity CQI audit tool weekly times 4 weeks then every 2 weeks times 4 weeks then monthly for at least 6 months. The CQI forms will be reviewed during facility CQI meeting. If threshold is not achieved an action plan will be developed. 5. 5. Completion Date: 2/23/23	

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	light response, ability to receive showers as scheduled are frequently brought up in resident council meetings. She indicated the worst response times are when there was only one aide on each hall or one aide covering both halls, during evening and night shifts. During a record review beginning 1/26/23 at 12:48 PM, resident council minutes were reviewed. Minutes from October 2022 indicated resident expressed a concern about call light response. During an interview with the Administrator on 1/24/23 at 12:50 PM she indicated there is no facility policy specific to call light response times. She stated response depends on the needs of the residents, emergencies, showers etc., She indicated staff schedules are based on financial goals and are adjusted to meet acuity needs. She indicated the management team is expected to come in and assist when shortages occur. She indicated there are not specific numbers that are set due to variable acuity factors. This Federal citation is related to complaint IN00396009. 3.1-17			