STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 00 B. WING	11/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KOKOMO HEALTHCARE CENTER	429 W LINCOLN RD KOKOMO, IN 46902

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00420789 and IN00420085. Complaint IN00420789 - Federal/State deficiencies related to the allegations are cited at F609 and F740. Complaint IN00420085 - Federal/State deficiencies related to the allegations are cited at F740. Survey dates: October 30, 31 and November 1, 2, 3 and 6, 2023. Facility number: 000127 Provider number: 155222 AIM number: 100291430 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 2 Medicaid: 52 Other: 15 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on November 14, 2023.	F 0000	Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0565 SS=E	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response			

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

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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Bldg. 00	§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on interview and record review, the facility	F 0565	**Corrective actions**	12/07/2023

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	failed to respond to concerns the resident council group brought up during their resident council meetings for 12 of 12 resident council meeting minutes reviewed. Finding includes: During a review of the resident council meeting minutes, on 10/5/23 at 3:00 p.m., the residents had brought up the following: a. New ideas for activities. b. A request to have more resident parties. c. Concerns with stained laundry. d. Concerns with call lights. e. Concerns with housekeeping taking trash. f. Maintenance concerns. The minutes did not indicate if the concerns brought up from the resident council group had been considered. The meeting minutes had a space, titled "Old business," and this space was marked as NA (not applicable) or "good follow up". The meeting minutes did not include if the department managers were notified of the concerns brought up by the resident council group and any resolution to the concerns. During a resident council meeting, on 11/1/23 at 3:11 p.m., the resident council group indicated there were concerns brought up at the resident council meetings although the concerns did not get addressed at times. During an interview, on 11/3/23 at 2:11 p.m., the Activity Director indicated she would write the resident council meeting notes. The "Old Business" section of the resident council meeting minutes was for recording if the residents had "money problems". She did not put on the meeting minutes what happened the previous		**accomplished for those residents found to be affected by the alleged deficient practice:** No resident was harmed by the facilities alleged deficient practice. Facility created a new form for Resident Council Minutes with a section for documenting how concerns from previous meetings are being followed up on. Facility held an ad hoc resident council meeting on 11/15/23 and asked the committee to discuss any concerns that they felt like had not been followed up on. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents have the potential to be affected. Facility held an ad hoc resident council meeting on 11/15/23 and asked the committee to discuss any concerns that they felt like had not been followed up on. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Education was provided to the activities director on Resident Council policy with emphasis on how to properly document on the meeting minutes form and the process for completing grievances for any concerns brought up during resident council meetings. Social Services Director will oversee	

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	month at the resident council and what concerns or requests had been addressed. A current policy, titled "Resident Rights," dated as revised on 6/21/2021 and received from the Clinical Support Nurse on 11/6/23 at 1:43 p.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...The purpose of this policy is to guide employees in the general principles of dignity and respect of caring for residents...Procedure...Form or Participate in Resident Groups...Residents have a right to form or participate in a resident group to discuss issues and concerns about the facilities policies and operations such as a resident council...The facility will provide meeting space and must listen to and act upon grievances and recommendations of the group...." A current policy, titled "Resident Council," dated 4/22/21 and received from the Executive Director on 11/4/23 at 4:15 p.m., indicated "...Duties of the Resident Council include...Helping identify concerns...Serving as a sounding board for new ideas...Document the Resident Council Meeting on the Resident Council Minutes Form. Any concerns voiced at the meeting should be documented on the Concern Form and distributed to the appropriate Department Head..." 3.1-3(l)		Resident Council Meetings to ensure form is completed correctly and that concerns are being documented. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The ED/Designee will conduct monthly audits of resident council meeting minutes for 6 months to ensure any documented concerns are being followed up on and discussed with committee timely. If any discrepancies are noted in notification it will be immediately corrected and education will be provided. **The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.**	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or			

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	her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its			

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	admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to notify the physician and the resident's representative of a fall for 1 of 1 resident reviewed for notification. (Resident 64) Finding includes: During an interview, on 10/31/23 at 10:57 a.m., Resident 64's family member indicated they were not notified when the resident fell on 10/28/23. The record for Resident 64 was reviewed on 11/1/23 at 11:39 a.m. Diagnoses included, but were not limited to, hypertension, depressive disorder, and dementia. A post fall evaluation, dated 10/28/23 at 6:00 p.m., indicated the fall was unwitnessed and the resident indicated he hit his head on the floor. The resident was not sent to the hospital and the physician or family was not notified. A progress note, dated 10/30/23 at 10:48 a.m., indicated the Nurse Practitioner was notified two days after the fall. A late entry progress note, dated 10/30/2023 at 12:54 p.m., indicated Resident 64 was found on the floor at the end of his bed. The resident indicated he did not hit his head and there were no injuries. An IDT (interdisciplinary team) fall note, dated 10/30/23 at 11:03 a.m., indicated the resident was in the wrong wheelchair at dinner and did not	F 0580	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** No resident was harmed by the facilities alleged deficient practice. Resident 64's family was notified of fall on 11/1/23. The facility NP was notified of Resident 64's fall on 10/30/23. The facility did initiate Neuros at the time of the fall and completed them per policy with no abnormal findings. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents who have a fall have the potential to be affected. The facility reviewed the fall for the last 14 days to ensure the medical provider and family were notified no further discrepancies were noted. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Education was provided to all licensed nurses utilizing the fall management policy and notification of change policy with emphasis on notifying medical	12/07/2023

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	have anti-lock brakes. During an interview, on 11/2/23 at 3:15 p.m., the Corporate Support Nurse indicated they could not find any documentation the physician or resident's representative was called when the resident fell. A late entry note was charted, on 10/30/23, for the fall on 10/28/23. She had asked the nurse why she did not chart or call the physician and the resident's representative and the nurse had indicated she was just too busy. A current policy, titled "Fall Prevention and Management," dated as revised 6/1/22 and received from the Clinical Support Nurse on 11/6/23 at 1:42 p.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs, concerns of the residents...Fall prevention and management is the process of identifying risk factors that can minimize the potential for falls and also a process to manage a resident's care if a fall occurs...The family and physician should then be notified with the information obtained. Document all interventions and family/physician notification...." A current policy, titled "Notification of Change in Condition," not dated and received from the Clinical Support Nurse on 11/6/23 at 1:42 p.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs, concerns of the residents...The purpose of this policy is to provide guidance for notification made to residents, resident representatives, and authorized family members for resident changes in condition. Changes may include but are not limited to accidents, incidents, transfers, changes in overall health status, significant medical		provider and family after a fall. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The DON/Designee will conduct audits of 5 per week for 4 weeks, then 3 falls per week for 4 weeks, then 1 fall per week for 4 months in the clinical meeting to ensure medical provider and family have been notified of the event. If any discrepancies are noted in notification it will be immediately corrected and education will be provided. **The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.**	

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	changes...The attending practitioner is promptly notified of significant changes in condition...When a change in condition is noted, the nursing staff will contact the resident representative...." 3.1-5(a)(1)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate			

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	corrective action must be taken. Based on interview and record review, the facility failed to report to the state agency a drug overdose which resulted in the use of Narcan (a medication used to treat narcotic overdose) and a hospitalization for 1 of 2 residents reviewed for behavioral health. (Resident C) Finding includes: The record for Resident C was reviewed on 11/1/23 at 10:23 a.m. Diagnoses included, but were not limited to, protein calorie malnutrition, anxiety disorder, a history of malignant neoplasm of the tongue, and chronic pain syndrome. A progress note, dated 10/27/23 at 10:33 a.m., indicated Resident C was found unresponsive by a staff member at 9:32 a.m., when the staff member entered the room to administer morning medications. Cardiopulmonary Resuscitation (CPR) was initiated, and Emergency Medical Services (EMS) arrived at 9:40 a.m. The resident was transported to the hospital at 9:56 a.m. A progress note, dated 10/27/23 at 11:40 a.m., indicated the resident was unresponsive and 911 was called. The EMS administered Narcan, and the resident was then responsive. The EMS found drug paraphernalia on the resident's bed after he was moved to the EMS gurney. The resident was transferred to the hospital by EMS. A hospital admission note, dated 10/27/23, indicated the resident had an opioid overdose. A crack pipe was found underneath the resident by the EMS. The resident tested positive for opiates, cocaine, and benzodiazepines. A hospital discharge summary, dated 10/28/23,	F 0609	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident C returned from the hospital with no new orders and is at his baseline. Facility updated plan of care to reflect the history of substance abuse. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** Any resident with opioid use has the potential to be affected. The facility reviewed the charts of all residents with a history of substance abuse or prescribed opioids for the last 30 days. There were no other residents that required the use of Narcan that resulted in a hospitalization. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Education was provided to ED on how an alleged violation of a drug overdose that resulted in the use of Narcan and a hospitalization is to be reported to the state agency. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The RDO/Designee will conduct weekly audits for the first 4 weeks, then monthly for the next	12/07/2023

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	indicated Resident C's admission diagnosis was an opioid overdose and the discharge diagnosis was an opioid overdose. The resident presented to the Emergency Department after he was found unresponsive with pinpoint pupils and had no pulse. He received brief CPR. He admitted to smoking cocaine about four times a week and he had inhaled heroin on the day of admission. A crack pipe was found at the skilled nursing facility and the resident was laying on it. There was not a facility reported incident (FRI) to the State Agency to include Resident C's overdose, drug possession, and hospitalization. During an interview, on 11/1/23 at 11:09 a.m., an anonymous staff indicated she was told to keep quiet about the resident's overdose. During an interview, on 11/1/23 at 11:36 a.m., the Executive Director (ED) indicated she was in the building, on 10/27/23, when Resident C was getting chest compressions. The emergency medical technicians arrived and found some questionable items in the resident's room. The police were called and found a glass pipe in the room. The resident had overdosed on crack cocaine and heroin. The facility was not aware of any substance abuse issues with the resident until he went to the hospital for the overdose. She was not aware the incident had to be reported to the state agency. During an interview, on 11/1/23 at 11:40 a.m., the Director of Nursing (DON) indicated she was not aware a resident's overdose needed reported to the state agency. During an interview, on 11/1/23 at 11:41 a.m., the Clinical Support Nurse indicated she was not		5 months on Narcan administration that results in a hospitalization to ensure any concerns were reported to the state agency. **The results of the audit observations will be reported reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.**	

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	aware a resident's overdose needed reported to the state agency. The facility had not provided a policy for reporting to the state agency by the time of exit. This Federal tag relates to Complaint IN00420789. 3.1-28(c)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS) assessment was coded correctly for a resident who had a Preadmission Screening and Resident Review (PASARR) Level II completed for 1 of 2 residents reviewed for PASARR. (Resident 63) Finding includes: The record for Resident 63 was reviewed on 11/3/23 at 2:54 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, schizoaffective disorder, and moderate protein-calorie malnutrition. A PASARR Level II, dated 2/9/23, indicated the resident had a serious mental illness due to the diagnoses of schizoaffective disorder and schizophrenia. This was considered a PASARR Level II condition. An annual MDS assessment, dated 5/17/23, indicated the resident did not have a PASARR Level II condition.	F 0641	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident 63's MDS modified to code for Level II PASRR. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** The Regional MDS Director will review each resident with a diagnosis requiring a level 2 to ensure coding is correct on the MDS. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The Regional MDS Director or designee will re-educate the facility MDS Coordinator on the guideline for accurate coding of the MDS per the RAI guidelines.	12/07/2023

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	During an interview, on 11/3/23 at 1:58 p.m., the MDS Coordinator indicated the resident did not have a PASARR Level II marked on the MDS assessment, dated 5/17/23. The resident did have a PASARR Level II, and this should have been marked on the MDS assessment. During an interview, on 11/6/23 at 4:55 p.m., the Clinical Support Nurse indicated the facility did not have an MDS policy and used the Resident Assessment Instrument (RAI) manual for MDS assessments. 3.1-31(d)(3)		**How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audit for all residents Level 2 and discharge planning will be conducted by the Regional MDS Director or designee weekly times 8 weeks, then monthly times 4 months to ensure compliance: review each resident requiring a Level II to ensure the most recent MDS is coded correctly for Level II PASRR. **The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.**	
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			

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	155222	A. BUILDING 00 B. WING	11/06/2023

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KOKOMO HEALTHCARE CENTER	429 W LINCOLN RD KOKOMO, IN 46902

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	possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to implement the Preadmission Screening and Resident Review (PASARR) Level II recommendations for 1 of 2 residents reviewed for PASARR. (Resident 63) Finding includes: During an interview, on 10/31/23 at 11:48 a.m., Resident 63 indicated he was working on his own arrangements to live somewhere else. He did not have a case manager and had signed up for the housing authority. He had applied for an apartment and the apartment complex needed more information. The record for Resident 63 was reviewed on 11/3/23 at 2:54 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, schizoaffective disorder, and moderate protein-calorie malnutrition. A care plan, dated 6/5/22, indicated the resident wanted to be discharged to home. The interventions included, but were not limited to, discuss with rehab any special equipment needs, provide education to the resident regarding obtaining equipment, and to notify the medical provider of discharge plans. The care plan did not include any case management services to explore community living. A PASARR Level II, dated 2/9/23, indicated the resident needed the following rehabilitative services:	F 0644	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** No residents were harmed by the facilities alleged deficient practice. Resident 63's PASRR Level II recommendations were reviewed and added to the plan of care. Resident 63 was referred to therapy for evaluation of DME for discharge with no changes to current plan. SSD discussed discharge plans with NP. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents who trigger for a Level II have the potential to be affected. The facility reviewed all residents who required a Level II and updated the plan of care with any recommendations. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Education was provided to Social Services utilizing the Indiana PASRR policy with emphasis on following recommendations and ensuring they are added to the plan of care.	12/07/2023

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	a. Supportive counseling from the nursing facility staff. b. Training in community living skills. c. Training in self-healthcare management. d. Training on activities of daily living skills. e. Case management to explore community living. f. Crisis intervention. g. Occupational therapy evaluation. h. Physical therapy evaluation. i. Family involvement in care. j. Medication review k. Individual mental health therapy. l. Psychiatric evaluation. The PASARR Level II indicated the reason for the psychiatric evaluation was to clarify the diagnosis and to recommend treatment. The case management was needed for discharge planning to make referrals to any services needed. The resident would benefit from training on health needs and daily care needs to be more successful in a community living setting. The PASARR Level II recommendations were not included in the resident's care plan. A PASARR Level II, dated 4/17/23, indicated the resident met PASARR criteria for mental illness based on the diagnosis of schizoaffective disorder and would need to be provided the following rehabilitative services by the facility: a. Supportive counseling from the nursing facility staff. b. Family involvement in care. c. Medication review. d. Individual mental health therapy. e. Outpatient mental health treatment services. f. Socialization/leisure/recreation activities. The care plan did not include any of the PASARR		**How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The SSD/Designee will conduct audits of 5 residents per week for 4 weeks then, 3 residents per week for 4 weeks then 1 resident per month for 4 months to ensure the PASRR Level II recommendations were completed and added to the plan of care. Any discrepancies will be immediately corrected and education we will provided. **The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.**	

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	services to be provided. During an interview, on 11/1/23 at 11:29 a.m., the Social Services Director (SSD) indicated the resident was wanting to live on his own. He had applied to a local apartment complex. He did not have a case manager to assist with the applications even though the PASARR Level II indicated the resident needed a case manager to help him get alternative living arrangements. The SSD was not aware of the PASARR Level II recommendations. The resident had been at the facility for over one year and was still trying to make alternative living arrangements on his own. During an interview, on 11/3/23 at 1:58 p.m., the Minimum Data Set (MDS) Coordinator indicated the PASARR Level II was not included on the MDS assessment. Since the MDS assessment was not coded correctly, the PASARR Level II recommendations did not get added to the care plan. She thought the resident refused a psychiatric evaluation although she was not sure. During an interview, on 11/6/23 at 10:32 a.m., the Executive Director (ED) indicated there was no documentation in the Electronic Health Record (EHR) about the resident applying for alternate places to live. The care plan meeting notes did not include the resident was applying for alternate living arrangements or if the facility was assisting with the living arrangements. The resident had declined a psychiatric evaluation and was not receiving mental health services. There was no documentation in the EHR to show the resident refused the psychiatric services or if the services were offered.			

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	A current policy, titled "Indiana PASSR," dated as reviewed 8/24/2020 and received from the Clinical Support Nurse on 11/6/23 at 4:15 p.m., indicated "...The preadmission screening and resident review process, otherwise known as PASRR, is a federally mandated process to ensure nursing facility applicants and resident with serious mental illness and/or intellectual and development disabilities are identified and placed appropriately in the least restrictive setting. PASRR ensures that persons with disability are admitted or allowed to remain in a particular nursing facility only if they can be appropriately served in the facility. PASRR ensures that individuals are provided with the disability services they need, including rehabilitative and specialized services. The goal of PASRR activity is to optimize each individual's placement success, treatment success, and ultimately, the individual's quality of life...The PASARR Level II evaluation identifies rehabilitative or specialized services that an individual may require...." 3.1-16(d)(1)(B)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services			

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	staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to ensure care plan meetings included the resident and were documented in the Electronic Health Record (EHR) for 2 of 2 residents reviewed for care plan meetings. (Resident 63 and 32) Findings include: 1. During an interview, on 10/31/23 at 11:48 a.m., Resident 63 indicated he had not had a care plan meeting since he first arrived to the facility. The record for Resident 63 was reviewed on 11/3/23 at 2:54 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, schizoaffective disorder, and moderate protein-calorie malnutrition. During an interview, on 11/6/23 at 10:32 a.m., the Executive Director (ED) indicated the Social Services Director (SSD) did not have a laptop and would enter her information on paper and then later into her desktop. A paper copy of the resident's care plan meeting was provided by the	F 0657	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** No residents were affected by the alleged deficient practice. Resident 63 had a Care Conference meeting on 11/7/23, Resident 32 had a Care Conference meeting on and documentation was completed in the electronic health record by Social Services. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents have the potential to be affected. The Social Services Director completed an audit of all residents to ensure a care conference was held within the last quarter. Any resident who has	12/07/2023

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	ED. A care plan communication, dated 5/17/23 and received from the ED on 11/6/23 at 10:40 a.m., indicated the family was not invited. The SSD, Director of Nursing, and Activities Director attended the meeting. The resident's code status, shower days, and diet were reviewed. A care plan communication, dated 8/23/23, indicated the resident's family was not invited. The SSD, dietary staff, Director of Nursing, and Activities Director attended the meeting. The resident's code status, shower days, and diet were reviewed. The care plan communications did not include the time of day of the meeting, if the resident was in attendance for the meeting, or if the resident's discharge plans were discussed. 2. During an interview, on 10/31/23 at 10:01 a.m., Resident 32 indicated he did not remember having a care plan meeting in a long time. The record for Resident 32 was reviewed on 10/31/23 at 4:21 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the right dominant side, occlusion/stenosis of the left carotid artery, personal history of a TIA (transient ischemic attack), atrial fibrillation (irregular heart beat), hypertension (high blood pressure), cardiomegaly (enlarged heart), COPD (chronic obstructive pulmonary disease), convulsions, alcohol dependence, history of traumatic brain injury, major depressive disorder, edema (swelling), and personality disorder. A care plan communication note, dated 6/21/23, indicated a care plan meeting was held for the		not had a care conference was added to a schedule and a care conference will be completed before the end of 2023. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Education was completed with SSD by the Administrator utilizing the Care plan overview policy with emphasis on conducting a care conference quarterly with each residents and completing documentation of the care conference in the electronic health record. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** SSD/Designee will audit 5 residents per week x4 weeks, then 3 residents per week x 4 weeks, then 1 resident per month for 4 months to ensure a care conference was completed quarterly with each residents and completing documentation of the care conference in the electronic health record. **The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.**	

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	resident. The resident's daughter was invited but did not attend. The Social Services Director, Activities Director, Dietary Manager, and the DON (Director of Nursing) attended. His code status was to provide CPR. He was to be showered 2 days a week, and he was on a regular diet. Questions or concerns were addressed. The meals were discussed and there were no concerns at this time. He was not interested in having all his teeth pulled. The care plan communication note did not indicate if the resident was present, or if the care plan was discussed with him. A care plan note, dated 9/19/23 at 11:17a.m., indicated the resident met with the Social Services Director and Business Office Manager to discuss the resident's unpaid bill for the dentist. There were no other care plan notes in the electronic medical record. During an interview, on 11/3/23 at 10:00 a.m., the Social Services Director indicated she had noted the care plan note which was completed on 9/19/23 regarding the dental bill. A current policy, titled "Plan of Care Overview," dated as revised 7/26/18 and received from the Clinical Nurse Consultant on 11/6/23 at 4:20 p.m., indicated "...the purpose of the policy is to provide guidance to the facility to support the inclusion of the resident or resident representative in all aspects of person-centered care planning and that this planning includes the provision of services to enable the resident to live with dignity and supports the resident's goals, choices and preferences including but not limited to, goals related to their daily routines and goals to			

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	potentially return to a community setting ...resident/ representatives will be offered opportunities to voice their view ...resident/representative will have the right to participate in the development and implementation of his/her own plan of care...review care plans quarterly and/or with significant change in cares...support the residents right to participate in treatment an d care planning...an interdisciplinary care team that participates in the planning and implementation of care may include but is not limited to...family, resident, resident representative or other individual the requests to be present...members of the care planning team will coordinate care to meet resident preferences and care needs utilizing a holistic approach...care plan documents are resident specific/resident focused and reflect resident/representative opportunities for participation and preferences...." 3.1-35(d)(2)(B)			
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 interview and record review, the facility failed to ensure a hospice binder was updated and showed ongoing communication between the hospice provider and the facility for 1 of 2 residents reviewed for hospice and end of life. (Resident 39)	F 0684	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** No residents were harmed by the alleged deficient	12/07/2023

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	Finding includes: The record for Resident 39 was reviewed on 11/02/23 at 10:52 a.m. Diagnoses included, but were not limited to, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) after a stroke, heart failure, and sequelae (residual effects) of a cerebral infarction (stroke). A physician's order, dated 6/14/23, indicated the resident was on hospice. Resident 39's hospice binder had the following visit entries: a. 5/22/23, seen by nurse. b. 5/23/23, seen by nurse. c. 5/29/23, seen by nurse. d. 6/2/34, seen by nurse. e. 6/5/23, seen by nurse. f. 7/21/23, seen by nurse. g. 10/30/23, seen by nurse. During an observation, on 11/01/23 at 10:53 a.m., a hospice staff member asked a facility staff member if she could sign her tablet to show she had visited the resident. The hospice staff member and facility staff member did not discuss what care was provided. During an interview, on 11/02/23 at 10:44 a.m., LPN 9 indicated she was unaware where the rest of the entries in the hospice binder were. During an interview, on 11/02/23 at 3:15 p.m., the Infection Preventionist indicated hospice usually saw residents twice per week and documented in the resident's hospice binders by the nurse's		practice. Resident 39's Hospice visit notes were obtained and updated in the resident's Hospice Binder on 11/2/23. The visit notes were reviewed by the DON for any changes in the plan of care with no findings. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All Residents who receive Hospice care have the potential to be affected. On 11/2/23 the facility audited all other Hospice binders to ensure visit notes were up to date with no other findings. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Education was provided to licensed nurses utilizing the Hospice Services policy with emphasis on communicating care via visit notes and ensuring they are placed in the hospice binders for each resident. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The DON/Designee will conduct audits of 3 Hospice residents charts per week for 4 weeks, then 2 charts per week for 4 weeks, then 1 resident chart per month for 4 months to ensure the visit notes are current and in the Hospice binders. Any	

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	station. She was unsure where the rest of the documentation was located. During an interview, on 11/3/23 at 9:58 a.m., the Executive Director of the hospice company indicated the hospice binders should be updated every 2 weeks. They preferred face to face reports, but the hospice binders should be updated every 2 weeks. A current hospice agreement, titled "HOSPICE CARE SERVICE AGREEMENT," dated January 2018 and received from the Administrator during entrance, indicated "...All communication between the Hospice and Nursing Facility pertaining to the care and services provided to the Resident Patient shall be documented in the Resident Patient's clinical record...." 3.1-37(a)		discrepancies will be immediately corrected and re-education will be provided. **The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.**	
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			

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	with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview and record review, the facility failed to ensure a resident with limited range of motion had a plan of care in place for accommodation of needs for 1 of 3 residents reviewed for limited range of motion. (Resident 63) Findings include: During an observation and interview, on 10/31/23 at 11:20 a.m., Resident 63 was sitting on the bed in his room. His head was tilted down towards his chest. He indicated he liked to watch television (TV) although he couldn't see the TV in his room because it was mounted on the wall. The TV was mounted on the wall close to the ceiling. He would like the TV to be moved where he could see it, but he did not like to ask for help. During an observation and interview, on 10/31/23 at 11:53 a.m., the resident indicated he was not able to move his neck due to a history of a tumor. Physical therapy was not able to help him, and he had a large hump on his left shoulder. The resident was not able to bring his head up to a normal position and his head was tilted down while talking. The record for Resident 63 was reviewed on 11/3/23 at 2:54 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, moderate protein-calorie malnutrition, schizoaffective disorder, and generalized edema. The diagnoses did not include the kyphosis (an excessive outward curvature of the spine causing a hunching of the back) or limited range of motion to the head and neck.	F 0688	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident 63 was referred to therapy for treatment of limited range of motion to identify any needed accommodations. Resident 63's T.V was also placed into his line of site. No other recommendations were noted. The diagnosis of Kyphosis was added and his plan of care was updated.** **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents with limited range of motion have the potential to be affected. The facility reviewed with therapy to ensure all residents identified with limited ROM have appropriate interventions in place on the plan of care.** **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Education was provided to all licensed nurses and rehabilitation services utilizing the Restorative Policy and Plan of care overview with**	12/07/2023

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	During an interview, on 11/6/23 at 2:41 p.m., the Physical Therapist indicated the resident's comfortable position was to have his head down. He had the problem since admission. The resident had kyphosis. The forward position of his head was more extreme, his shoulders were rounded forward, and it had caused a hunchback appearance. The resident kept his head down towards his chest and was only able to move it up a little. A care plan, initiated on 5/20/22, indicated the resident had an activities of daily living (ADL) self-care performance deficit and required assistance with ADLs due to weakness. The interventions included, but were not limited to, required assistance with bathing, dressing, ambulation, transfers, and eating. The resident preferred to get out of bed early in the morning and to go to bed late. The care plan did not include any interventions for the limited range of motion for the head and neck. A care plan, dated 11/16/22, indicated the resident had little or no activity involvement and wished to not participate. The interventions included, but were not limited to, assist with transport to activities as needed, assure the activities were compatible with the resident's physical and cognitive capabilities, to interview and determine the resident's activity preferences, and to offer the resident technology of interest such as a laptop and internet access. The care plan did not include the resident wanted to watch TV or accommodations for the resident to be able to watch TV in his room.		**emphasis on identifying limited range of motion and ensuring the plan of care is updated with interventions.** **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DON/Designee will conduct observations of 5 residents per week for 4 weeks, then 3 residents per week for 4 weeks, then 1 resident per month for 4 months to ensure resident with limited range of motion have interventions in place and care plan is up to date. The results of the audit observations will be reported reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.**	

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	155222	A. BUILDING 00 B. WING	11/06/2023

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	The care plans did not include the resident's kyphosis of his back. During an interview, on 11/6/23 at 10:32 a.m., the Executive Director (ED) indicated there was no documentation in the resident's care plan of his inability to move his head and neck to an upright position or accommodations for being able to view his television. A current policy, titled "Admission Evaluation," not dated and received from the Clinical Support Nurse on 11/3/23 at 11:08 a.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. A systematic evaluation is completed by a licensed nurse upon admission/readmission to assist in determining the most effective and appropriate care needs of each resident admitted to the center...Communicate Care Plan needs to team...." A current policy, titled "Plan of Care Overview," dated as revised on 7/26/2018 and received from the Clinical Support Nurse on 11/6/23 at 1:42 p.m., indicated "...for the purpose of this policy the Plan of Care, also Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care... It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...The facility will...Provide an RN [registered nurse] assessment of the resident as an on-going, periodic review that provides the foundation for resident focused care and the care planning process...Care plan documents are resident specific/resident focused and reflect			

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	resident/representative opportunities for participation and preferences...." 3.1-42(a)(2)			
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, interview and record review, the facility failed to assess and provide a plan of care for a resident with a history of substance abuse and to assess and provide an immediate plan of care for a resident who had a suicide attempt for 2 of 3 residents reviewed for mood and behaviors. (Resident C and B) Findings include: 1. The record for Resident C was reviewed on 11/1/23 at 10:23 a.m. Diagnoses included, but were not limited to, protein calorie malnutrition, anxiety disorder, a history of malignant neoplasm of the tongue, and chronic pain syndrome. An admission document, faxed to the facility on 10/4/21, included an internal medicine progress note which indicated the resident had a long history of nicotine and cocaine abuse.	F 0740	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** No resident was harmed by the facilities alleged deficient practice. Resident C's plan of care and medical diagnosis was updated with substance abuse history on 11/3/2023. Resident B's plan of care was updated with interventions from inpatient psych recommendations on 11/6/2023. The facility also updated Resident B's behavior monitoring to include suicidal ideation. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** Any	12/07/2023

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	The resident's care plans did not include the resident had a substance abuse history. A progress note, dated 10/27/23 at 11:40 a.m., indicated the resident was unresponsive and 911 was called. The Emergency Medical Services (EMS) administered Narcan, and the resident was then responsive. The EMS found drug paraphernalia on the resident's bed after he was moved to the EMS gurney. The resident was transferred to the hospital by EMS. A hospital admission note, dated 10/27/23, indicated the resident had an opioid overdose. A crack pipe was found underneath the resident by the Emergency Medical Services. The resident tested positive for opiates, cocaine, and benzodiazepines. A hospital discharge summary, dated 10/28/23, indicated Resident C's admission diagnosis was opioid overdose and the discharge diagnosis was opioid overdose. The resident presented to the Emergency Department after he was found unresponsive with pinpoint pupils and had no pulse. He received brief cardiopulmonary resuscitation (CPR). He admitted to smoking cocaine about four times a week and inhaled heroin on the day of admission. A crack pipe was found at the skilled nursing facility, and the resident was laying on it. During an interview, on 11/1/23 at 11:09 a.m., an anonymous staff indicated the resident left the facility every day about 12 noon or 1:00 p.m., and did not come back to the facility until 8:00 p.m., or 9:00 p.m. The resident did not have a care plan to monitor his mood and behaviors after returning from his		resident with a behavioral health history has the potential to be affected by the alleged deficient practice. Facility interviewed all residents on substance abuse history and updated plan of care as needed. Facility reviewed all residents with a history of suicidal ideation to ensure all interventions are updated in the plan of care. Clinical managers will review medical history of all new admissions to ensure behavioral health care plans are updated. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Education was provided to clinical managers on the Behavior Management Policy with emphasis on admission assessments with an emphasis on updating the plan of care with substance abuse history and immediately adding interventions to the plan of care to residents with behavioral health services. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The SSD/Designee will audit new admission assessments for 5 residents per week x4 weeks, then 3 residents per week x 4 weeks, then 1 resident per month for 4 months to ensure interventions are added to the plan of care for behavioral health	

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	daily leaves of absence. During an interview, on 11/1/23 at 11:23 a.m., the Social Services Director (SSD) indicated the resident was found unresponsive and the Emergency Medical Technicians (EMTs) saw a crack pipe in his room. The facility was not aware the resident was using illegal substances in the facility. The resident said one of his friends gave him the heroin. The SSD had not started a care plan for substance use. During an interview, on 11/1/23 at 11:36 a.m., the ED indicated the resident was found unresponsive, on 10/27/23, and had overdosed on crack cocaine and heroin. She was not aware of any substance abuse by the resident until he went to the hospital. She did not know his admission paperwork included the resident had a long-standing history of cocaine abuse.2. A FRI (Facility Reported Incident), dated 10/19/23, indicated Resident B had attempted suicide by using her call light cord to strangle herself. Staff heard gagging noises coming from her room and intervened. The resident was assessed and was sent out to the hospital for evaluation. The record for Resident B was reviewed on 11/1/23 at 1:32 p.m. Diagnoses included, but were not limited to, schizophrenia, generalized anxiety disorder, vascular dementia with agitation, and major depressive disorder. A progress note, dated 10/31/23 at 4:06 p.m., indicated the resident returned from the hospital. The family and provider were notified. A baseline care plan, dated 10/31/23, indicated the resident was assessed when she was readmitted from the hospital.		services. **The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.**	

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	The assessment did not address the resident's recent suicide attempt with initial interventions. During an observation, on 11/6/23 at 9:43 a.m., Resident B had a corded call light in her room. During an interview, on 10/6/23 at 10:03 a.m., the IP (Infection Preventionist) and the DON (Director of Nursing) indicated they would discuss the call light cord and the possibility of replacing it with a call bell instead without the cord. During an interview, on 10/6/23 at 10:29 p.m., the IP indicated the call light with the cord would not be removed. The initial baseline care plan did not include any suicide precaution interventions including the use of the corded call light. A current policy, titled "Admission Evaluation," received from the Clinical Support Nurse on 11/3/23 at 11:08 a.m., indicated "...Admission: the first 24 hours the resident is initially admitted to the facility or a re-admission of a resident who has been absent 24 hours...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the resident. A systematic evaluation is completed by a licensed nurse upon admission/readmission to assist in determining the most effective and appropriate care needs of each resident admitted to the center...Prioritize resident needs with appropriate interventions...Create a baseline care plan within 48 hours of admission...." A current policy, titled "Behavioral Management General," received from the Clinical Support Nurse			

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	on 11/6/23 at 4:15 p.m., indicated "...It is the policy of this facility to identify and safely manage residents who are exhibiting behaviors related to psychiatric diagnoses or who may present a danger to themselves or others...." A current policy, titled "Resident Substance Abuse in facility," not dated and received from the Clinical Support Nurse on 11/6/23 at 1:43 p.m., indicated "...Abused substances...for the purpose of this policy, is meant to imply drugs consumed by any route that have no medical use or drugs that are prescribed by a physician for other persons, or route or schedule...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors. The purpose of this policy is to provide guidance to the staff when substance abuse is confirmed or suspected in a resident and not intended to be step-by-step procedure. Each resident will be provided care based on their individual medical and emotional need...A facility may admit a resident who has a history or diagnosis of substance abuse. However, residents may not possess, use or provide any illicit drugs or abuse drugs in any manner, and may not have drug-related paraphernalia in their possession while a resident in the facility...." This Federal tag relates to Complaints IN00420085 and IN00420789. 3.1-37(a) 3.1-43(a)(2)			
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services			

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	The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for			

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	reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, interview and record review, the facility failed to ensure a resident had both his upper and lower dentures as documented in the admission assessment for 1 of 4 residents reviewed for dental services. (Resident 18) Finding includes: During an interview, on 10/30/23 at 2:13 p.m., Resident 18 indicated he lost his bottom teeth and was still looking for them. They were lost while he was sleeping. The record for Resident 18 was reviewed on 11/3/23 at 2:05 p.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes mellitus, chronic obstructive pulmonary disease, dependence on renal dialysis, major depressive disorder, and anxiety disorder. An admission assessment, dated 8/31/23, indicated the resident had a full set of dentures. A care plan, dated 9/8/23, indicated the resident had oral/dental problems, was edentulous (no natural teeth), and had a full set of dentures. The interventions included, but were not limited to, complete an oral assessment upon admission, dental consult as needed, and observe for dental problems including missing teeth. A care plan, dated 9/8/23 and last revised on 11/1/23, indicated the resident had a potential for altered nutritional status. The interventions included, but were not limited to, ensure dentures were utilized for meals.	F 0791	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** No residents were affected by the alleged deficient practice**.** Facility contacted resident' 18's previous facility that resident stated he lost his bottom dentures at. Previous facility is attempting to locate the bottom dentures. Resident 18 has a dental appointment scheduled for 12/5/23. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents have the potential to be affected by the alleged deficient practice. Facility completed a whole house audit on admission assessment documentation to ensure all were accurate and reflected current dental status. Any residents with discrepancies will be scheduled for a dental appointment. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Education was provided to all licensed nurses on the Dental Services policy with an emphasis on documenting accurately in	12/07/2023

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	During an interview, on 11/6/23 at 2:55 p.m., the Clinical Support Nurse indicated the resident lost his bottom dentures at a previous facility. She looked at the admission assessment and it indicated the resident had upper and lower dentures. An inventory of the resident's dentures upon admission could not be located. A current policy, titled "Dental Services," not dated and received from the Clinical Support Nurse on 11/6/23 at 4:15 p.m., indicated "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the resident...Dental and Oral health can impact the physical as well as the mental/emotional and psychological health of a resident. Poor dentition and/or poor oral health may impact nutritional and weight loss status...For Medicaid residents...The facility must provide all emergency dental services and those routine dental services to the extent covered under the Medicaid state plan...The facility must inform the resident of the deduction for the incurred medical expense available under the Medicaid State plan and must assist the resident in applying for the deduction...If any resident is unable to pay for dental services, the facility should attempt to find alternative funding sources of delivery systems so that the resident may receive the services needed to meet their dental needs and maintain his/her highest practicable level of well-being...." 3.1-24(a)(3)		admission assessments. Education was provided to Social Services on completing inventory for each new resident. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The SSD/Designee will conduct a weekly audit for 4 weeks, a biweekly audit for 8 weeks, then monthly audit for 3 months on admission assessment documentation to ensure new resident's dental status is documented accurately and matches the inventory. **The results of the audit observations will be reported reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.**	
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility			

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	provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to ensure meals were served at a safe and appetizing temperature for 1 of 1 tray tested for a safe and appetizing temperature. (200 Hall) Finding includes: During an interview, on 10/30/23 at 2:11 p.m., Resident 18 indicated the food was terrible. It did not taste good. The food was cold when it should be hot. He had made complaints, but it did not change. During an interview, on 10/30/23 at 3:02 p.m., Resident 274 indicated her food was not warm when it was delivered to her room. During an observation, on 10/31/2023 at 12:47 p.m., the Dietary Manager used the facilities thermometer and tested a tray. The beef enchilada was 137.7 degrees Fahrenheit (F), the rice was 134.4 degrees, and the refried beans was 127.7 degrees. During an interview, on 10/31/23 at 12:55 p.m., the Dietary Manager indicated the temperature of the refried beans, rice, and beef enchilada were all under the recommended temperatures. The beef enchilada should be served at 145 degrees or greater. The refried beans and rice should be	F 0804	**IDR reasoning: Facility has sufficient evidence that contradicts the citation** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** No resident was harmed by the facilities alleged deficient practice. Facility was unaware of the concern until the next day. Residents 274 and 18 were encouraged to attend dining room for meals and educated that staff can heat their meals up at any time. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents have the potential to be affected by this alleged deficiency. Facility will encourage all residents to eat in the dining rooms and ask for trays to be reheated if needed. **Measures put in place and systemic changes made to ensure the alleged deficient**	12/07/2023

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	served at 135 degrees or greater. The food on the tray would need to be reheated. A current policy, titled "Food: Quality and Palatability," dated as revised 9/2017 and received from the Clinical Support Nurse on 11/6/23 at 1:42 p.m., indicated "...Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature...Food should be at the appropriate temperature as determined by the type of food to ensure resident's satisfaction minimizes the risk for scalding and burns...The Cook(s) prepare food in a sanitary manner utilizing the principles of Hazard Analysis Critical Control Point (HACCP) and time and temperatures guidelines as outlined the Federal Food Code...." 3.1-21(a)(2)		**practice does not recur:** Education was provided to the dietary manager on the Food Quality and Palatability with an emphasis on safe and appetizing food temperature ranges with an emphasis on resident preferences. The facility educated new dietary manager on safe and appetizing food temperature ranges with an emphasis on resident preferences. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The Dietary Manager/Designee will conduct random meal trays audits for 5 residents per week x4 weeks, then 3 residents per week x 4 weeks, then 1 resident per month for 4 months to ensure all meals are at safe and appetizing food temperature ranges. Any discrepancies will be corrected immediately and education will be provided. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure the ice scoop was stored in a container, the handwashing station had running water, and a trash can was available at the handwashing station. This deficient practice had the potential to affect 70 of 70 residents who received food from the kitchen. Findings include: During a tour of the kitchen, on 10/30/23 at 1:07 p.m., with the Dietary Manager (DM) the following was observed: 1. The handwashing station's sink did not have running water. The white plumbing pipe was sitting in the sink. 2. The ice scoop was sitting on a wire shelf with other supplies and not stored in a container.	F 0812	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** No residents were affected by the alleged deficient practice. Dietary staff immediately sanitized ice scoop before using it to serve with. The white plumbing pipe was repaired the same day to allow running water to drain properly. Kitchen staff were educated to utilize the handsfree trashcan for the handwashing station. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents have the potential to be	12/07/2023

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	155222	A. BUILDING 00 B. WING	11/06/2023

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	3. The handwashing sink did not have a trash can. The staff were using the trash can for dirty linen. During an interview, on 10/30/23 at 1:10 p.m., the DM indicated the handwashing sink had not worked for a while. The staff were washing their hands in the sink by the dishwasher or the three-compartment sink. The handwashing sink should have been fixed and the staff should not use the sink which was used for dishwashing. During an interview, on 10/30/23 at 1:13 p.m., the DM indicated the ice scoop should be in a container and not sitting on the wire shelf with other items. The ice scoop would be considered dirty. During an interview, on 10/31/23 at 11:31 a.m., Cook 6 indicated the hands-free trash can was being used for soiled linen. The staff used the large trash can by the dishwasher. During an interview, on 10/31/23 at 11:33 a.m., the DM indicated she used her elbow to prop the lid up on the large trash can. There should be a hands-free trash can by the hand washing sink. During an interview, on 10/31/23 at 11:35 a.m., Cook 7 indicated she would wash her hands and use a paper towel to open the large trash can lid and place the towels in the large trash can. A current policy, titled "Environment," revised on 9/2017 and received from the Administrator on 11/1/23 at 10:00 a.m., indicated "...All food preparation areas, food services areas, and dining areas will be maintained in a clean and sanitary condition...The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing		affected by the alleged deficient practice. Facility completed an audit on Kitchen to ensure all food preparation, service, and dining areas were being maintained in a clean and sanitary condition. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Education was provided to all dietary staff employees on the Environment policy with emphasis on ensuring all food preparation/service/dining areas were being maintained in a clean and sanitary condition and the process of sanitizing service equipment. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The ED/Designee will conduct a weekly kitchen sanitation audit for 24 weeks to ensure all food preparation, service, and dining areas were being maintained in a clean and sanitary condition. Any discrepancies will be immediately corrected and education will be provided. The results of the audit observations will be reported reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.	

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	of all food service equipment and surfaces...All trash will be contained in covered, leak-proof containers that prevent cross contamination...." 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;			

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	(ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to ensure dirty clothes,	F 0880	**Corrective actions accomplished for those**	12/07/2023

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	cardboard boxes, and piles of clean clothes were not touching the ground for 3 of 3 rooms reviewed for infection control. (Room 215, 414 and 416) Findings include: During a tour, beginning at 9:20 p.m., on 11/3/23, with the Administrator and the Maintenance Director, the following were observed: 1. Room 215 had multiple cardboard boxes on floor. 2. Room 414 had a large cardboard box on the floor with linen, a hospital gown, and a medium size duffle bag on the top of the box. 3. Room 416 had a pair of dirty jeans, a plaid shirt, and a wet towel on the floor. There were three stacks of clean clothes by the window. During an interview, on 10/31/23 at 10:00 a.m., Certified Nursing Assistant (CNA) 2 indicated dirty clothes should never be left on the floor. The dirty clothes should be bagged and put in the soiled linen cans. During an interview, on 10/31/23 at 10:07 a.m., Qualified Medical Assistant (QMA) 4 indicated dirty clothes and cardboard boxes should never be left on the floor. During an interview, on 10/31/23 at 10:10 a.m., the Social Services Director indicated the dirty clothes in Room 416 should not be left on the floor. The piles of clothes should be put up in their drawers and not on the floor this could be a hazard. A current policy, titled "Infection Control Practices for Laundry/Linens," dated as revised		**residents found to be affected by the alleged deficient practice:** Room 215 was provided with plastic storage containers, linen and laundry were removed from room 414 and 416, and cardboard boxes from 414 and 416 were disposed of to ensure facility was in compliance with infection control policy. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents have the potential to be affected by the alleged deficient practice. Facility completed a whole house audit of resident rooms to ensure there were no other residents being affected by the alleged deficient practice and addressed any discrepancies immediately. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Education was provided to all direct care staff on the infection control policy with emphasis on linen, laundry, and cardboard boxes. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The ED/Designee will conduct observations of 5 residents per week for 4 weeks, then 3 residents per week for 4	

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	6/21/17 and received from the Clinical Support Nurse on 11/6/23 at 1:44 p.m., indicated "...Provide the storage, handling and processing of linen activities following practices to decrease the risk of spreading infection and exposure to bloodborne pathogens. Consider all soiled linen contaminated and treat and handle such...Soiled linen is placed in hampers or carts at or near the location where it was used. Soiled linen carts or hampers shall be covered with a lid...." 3.1-18(b)		weeks, then 1 resident per month for 4 months to ensure dirty clothes, cardboard boxes, and piles of clean clothes are not touching the ground. Any discrepancies will be corrected immediately and education will be provided. **The results of the audit observations will be reported reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.**	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §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 toilet bowls and towel racks were clean, walls were free from marks, scratches, peeling wallpaper, gouges, and paint chips, rooms were free from dirty clothes and piles of clean clothes on the floor, toilet bolts were covered, and a dining plan was established when the dining room was closed for remodeling for 9 of 9 rooms and the main dining room observed for environment. (Room 201, 204, 208, 215, 312, 414, 416, 424 and 425) Findings include: During a tour, beginning at 9:20 p.m., on 11/3/23, with the Administrator and the Maintenance Director, the following were observed:	F 0921	**What corrective actions have been accomplished for those residents found to have been affected by the deficient practice;** No residents were harmed by the facility's alleged deficient practice. Paint touch up and repairs requests have been submitted for rooms 201, 204, 208, 312, 414, 416, 424, and 425. All toilets were cleaned and bolt covers were replaced on 10/31/23. Facility provided a plastic storage container for 215 and disposed of cardboard boxes. Clothes in room 416 were removed immediately during the survey. Construction for the dining room was started as	12/07/2023

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	1. Room 201 had missing bolt covers on both sides of the toilet sticking up 2 or 3 inches. The toilet bowl had a brown ring in the bottom and the towel bar had dried scum. 2. Room 204 had a bolt on the right side of the toilet sticking out about 3 inches and there was a round toilet seat on an oblong toilet. 3. Room 208 had toilet bolts which were sticking up about 2 inches and were not covered. 4. Room 215 had multiple cardboard boxes on the floor. 5. Room 312 had chipped paint on the walls and an area of wallpaper peeling off near the ceiling. 6. Room 414 had a large cardboard box on the floor, the wall behind the bed had gouges and approximately a 2 foot(ft) by 2 ft area with black scuff marks. 7. Room 416 had a door with no trim. There were gouges on the wall with peeled off paint around the door and along bottom of the wall. There were a pair of dirty jeans, a plaid shirt, and a wet towel on the floor in the middle of the room and three stacks, approximately 2 foot tall, of clean clothes on the floor by the window. During an interview, on 10/31/23 at 10:10 a.m., the Social Service Director indicated in Room 416 the dirty clothes should not be left on the floor and the piles of clothes should be put up in their drawers and not stacked on the floor. 8. Room 424 had missing baseboard trim around the bottom of sink and under the sink was a white board placed against the left wall.		planned on 11/1/23 during the survey and completed by 11/17/23. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** All residents have the potential to be affected. The facility completed a whole house audit to identify any additional repairs needing to be made. Facility will utilize Room Readiness audit tool for any new admissions to ensure repairs are made before admissions enter. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Education on Room Readiness policy with an emphasis on storage of linens and laundry will be completed with the Maintenance staff and housekeeping with an emphasis on ensuring environment is safe/functional/sanitary/comfortable. **How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;** The ED/Designee will audit 5 rooms per week for 4 weeks then, 3 rooms per week for 8 weeks then, 1 room per week for 12 weeks to ensure environment is	

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	9. Room 425 had a large area of paint peeled from behind the bed. 10. During an observation, on 10/30/23 at 1:00 p.m., the main dining room was located by the kitchen. The doors were closed, and a sign indicated the dining room was closed for remodeling. During an observation, on 10/31/23 at 12:00 p.m., the residents were painting in a room used for activities and dining located on the 400 Hall. During an observation, on 10/31/23 at 12:25 p.m., the lunch trays arrived on the 400 Hall. The residents continued to paint. A Certified Nursing Assistant (CNA) started to pass meal trays out to the residents and the Activities Director stopped the CNA. Painting supplies were covering all the tables and there was no place for the lunch trays. The Activities Director stopped the painting, and the residents were told to either go to their rooms or the 200 Hall dining room for lunch. During an observation, on 10/31/23 at 12:30 p.m., the 200 Hall dining room had nine residents sitting at six tables. There were three tables against the windows and three tables in the center of the room. Two vending machines were against the right wall and chairs were lined up against the left wall. The room was small and crowded with very little room to maneuver wheelchairs. During an interview, on 10/30/23 at 1:07 p.m., the Dietary Manager (DM) indicated the main dining room was closed for remodeling. The facility was using a room on the 400 Hall and the 200 Hall for dining. The DM did not know when the main dining room would be completed.		safe/functional/sanitary/comfortable. Any discrepancies will be immediately corrected and re-education will be provided. Results of the audit will be brought to QAPI for six months or until 100% compliance is achieved. Any discrepancies will be correctly immediately	

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	During an interview, on 11/03/23 at 9:31 a.m., the Maintenance Director indicated they were working on the building. They purchased paint and putty to patch the walls and were working on the halls. During an interview, on 11/3/23 at 9:37 a.m., the Administrator indicated they were doing a large renovation project. They were painting and remodeling the main dining room. The boxes and clothes should not be on the floor, and they were having a hard time finding trim for the doors. The facility did not have an environmental policy. 3.1-19(f)(5)			