STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155836	A. BUILDING 00 B. WING	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CUMBERLAND TRACE HEALTH & LIVING COMMUNITY	1925 REEVES ROAD PLAINFIELD, IN 46168

(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 IN00399873 and IN00395302. This visit included a State Residential Licensure Survey. Complaint IN00399873 - Unsubstantiated due to lack of evidence. Complaint IN00395302 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Survey dates: February 7, 8, 9, 10, 13, 14, 15, and 16, 2023. Facility number: 013455 Provider number: 155836 AIM number: 201293440 Census Bed Type: SNF/NF: 64 SNF: 29 Residential: 59 Total: 152 Census Payor Type: Medicare: 24 Medicaid: 44 Other: 25 Total: 93 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 2, 2023.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Trei Barnett	Administrator	03/16/2023

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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F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation			

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	to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on record review and interview, the facility failed to ensure an advance directive was documented accurately in the medical record for 1 of 1 residents reviewed for advanced directives (Resident 88). Findings include: On 2/8/23 at 10:17 a.m., the medical record was reviewed for Resident 88. The diagnoses included but was not limited to hemiplegia and hemiparesis (paralysis on one side of the body) following cerebral infarction (stroke) affecting the right dominant side. The face sheet indicated DNI (do not intubate) for code status. The physician order, dated 1/31/23, indicated, "Full Code." The care plan, dated 1/5/23, indicated, "The resident has requested to have a DNR [do not resuscitate] code status." The target date was 4/5/23 and indicated, "The resident's wishes will be honored." Resident 88 had a Physician Orders for Scope of Treatment form (POST) scanned into the electronic record. This document, dated 1/5/23, signed by Resident 88 and the Nurse Practitioner, on that date, indicated, " Attempt Cardiopulmonary Resuscitation (CPR)...Limited additional interventions: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway	F 0578	**Cumberland Trace requests paper compliance for the following deficiencies. This plan of correction is to serve as Cumberland Trace's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Cumberland Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** · Resident 88 no longer resides at the facility. A correction was made to resident 88's chart upon the facility's knowledge of the inaccuracy. **II. The facility will identify other residents that may potentially be affected by the**	03/19/2023

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	management techniques and non-invasive positive air-way pressure. Do not intubate...." On 2/8/23 at 3:17 p.m., during an interview the Regional Nurse Consultant provided copies of Resident 88's advanced directive documents for review. She indicated Resident 88 was a do not intubate, but was to be a full code, just not intubated. The record had been updated to reflect the correct instructions. If the resident coded, when EMS (emergency medical services) arrived, they would have to tell them not to intubate. On 2/10/23 at 10:58 a.m., the Administrator provided a current, undated policy, titled "Advanced Directives." This policy indicated, "Cardon and Associates, Inc. and it's member communities are committed to promoting resident choice and honoring each resident's right to request, refuse or discontinue treatment and to formulate an advance directive...." 3.1-4(d) 3.1-4(f)(4)(A)(ii)		**practice.** · All residents who reside in the facility have the potential to be affected · A medical records review was completed for advanced directives on all current residents. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur** · Social Service staff and nursing staff were educated on the advanced directive policy and the importance accuracy in the medical record. **IV. The facility will monitor the corrective action by implementing the following measures.** - The DON or designee will review new admissions advanced directives to ensure accuracy and consistency of the advanced directives on the facesheet, the physician orders, and the care plan. - The DON or designee will review randomly 5 resident's advanced directives to ensure accuracy and consistency of the advanced directives on the face	

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			sheet, the physician orders, and the care plan weekly for 8 weeks, then 3 resident's advanced directives for 8 weeks, then 2 resident's advanced directives for 36 weeks - The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. **V. Plan of Correction completion date:** 3/19/2023	
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property			

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	from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to ensure hot water temperatures were kept within required temperature ranges for 2 of 17 resident rooms in the dementia unit sampled for hot water temperatures. Finding include: On 2/7/23 at 11:27 a.m., during a tour with maintenance man (MM) 25, he indicated Cardon communities preferred the resident's bathroom water temperatures between 110-120 degrees Fahrenheit (F). Seven resident rooms were checked, 5 of which were on the memory care secured unit. The rooms outside the required limit of 120 degrees F, were room 718 at 120.8 degrees	F 0584	**Cumberland Trace requests paper compliance for the following deficiencies. This plan of correction is to serve as Cumberland Trace's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Cumberland Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this**	03/19/2023

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	F. and room 609 at 123.2 degrees F. On 2/7/23 at 1:00 p.m., MM 25 provided all the building and resident temperature logs for January and the first week of February. He indicated he did not take or record any further temperatures from resident's rooms. On 1/4/23, the only resident room checked that week was room 509. MM 25 indicated he did not know he was supposed to check more resident rooms. Room 509 was within normal limits. On 1/18/23, MM 25 checked three resident rooms that week, rooms 521, 601, and 701. Room 601's bathroom temperature was 123 degrees F. On 1/25/23, MM 25 checked one resident room that week, room 722. It was within normal limits. On 2/1/23, MM 25 checked one resident room that week, room 523. Room 523's bathroom temperature was 125.3 degrees F. He indicated he adjusted the water temperature, but then was worried the other residents' water temperatures would be too low. On 2/13/23 at 10:05 a.m., the Maintenance man (MM) 25 indicated the memory care room 718's water temperature was 122.1 Fahrenheit (F). The other rooms checked were within normal limits. On 2/13/23 at 10:11 a.m., MM 25 indicated after two resident, on two different units, had bathroom water temperatures above an acceptable limit, he "tweaked" the hot temperature. Afterward, he found some residents hot water temperatures only reach 80 degrees F. He indicated the mixing valve was "messed up like it was frozen." He called a contracted company to repair/replace the mixing valve. The contracted company was at the facility		**submission constitute an agreement or admission of the survey allegations.** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** · The mixing valve was adjusted for rooms 718 and 609 at the noted time of temperature discrepancy. No residents were affected by the deficiency. **II. The facility will identify other residents that may potentially be affected by the practice.** · All residents who reside in the facility have the potential to be affected · A check was completed on the water temperature in all resident areas and adjustments were made when necessary. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur** · Maintenance staff was educated on the hot water policy. **IV. The facility will monitor the corrective action by implementing the following measures.**	

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	on 2/8/23, indicating the mixing valve needed to be replaced. The new mixing valve would come in next week. (2/20/23-2/24/23) On 2/13/23 at 10:56 a.m., MM 26 provided further resident temperatures; rooms 414, 425, 501, and 525. He indicated they were all within normal limits. A document titled, "Direct Supply," with no date, was provided by the Administrator, on 2/10/23 at 10:58 a.m. The Administrator indicated this document was the facility's hot water policy. A review of the policy indicated, " ...Ensure patient room water temperatures are between 105 degrees and 115 degrees Fahrenheit (or as specified by state requirements) ...Test temperature in shower areas ...test temperature at the mixing valve ...Check resident rooms at the end of each wing on a rotating basis ...." 3.1-19(r)(1) 3.1-19(r)(2)		- The Administrator or designee will review the hot water temperature log weekly for 8 weeks, then monthly for 8 weeks, then bi-monthly for 8 months. . See Attachment C - The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. **V. Plan of Correction completion date:** 3/19/23	
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 record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was coded to reflect serious mental illness for 2 of 3 residents (Residents 59 and 60) reviewed for Preadmission Screening and Resident Review (PASRR). Findings include: 1. On 2/10/23 at 10:45 a.m., Resident 59's medical record was reviewed. The diagnoses included, but	F 0641	**Cumberland Trace requests paper compliance for the following deficiencies. This plan of correction is to serve as Cumberland Trace's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Cumberland Trace or its management**	03/19/2023

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	was not limited to, psychotic disorder with delusions due to known physiological condition, major depressive disorder, recurrent severe without psychotic features and dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident 59's medication orders included but were not limited to Remeron 15 milligrams (mg) once a day for major depressive disorder, and Seroquel 25 mg once a day for psychotic disorder with delusions. A current care plan, dated 11/10/22, indicated Resident 60 had major depressive disorder with severe psychotic with common symptoms of verbal aggression, poor personal hygiene, and care refusals. Another care plan, dated 11/10/22 and reviewed on 1/18/23, indicated Resident 60 had a diagnosis of a psychotic disorder with delusions as his most common symptom. Resident 59's most recent annual, comprehensive MDS assessment, dated 5/6/22, section A1500 Preadmission Screening and Resident Review (PASRR) indicated "no" for "Is the resident currently considered by the state level II PASRR process to have serious mental illness and or intellectual disability or a related condition?" Section A1510 had no boxes checked for serious mental illness conditions. Resident 59's PASRR Level I screen, dated 9/27/21, indicated Resident 59 had serious mental illness but was not required to have a Level II evaluation due to a progressed neurocognitive disorder, dementia.		**company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** · Resident 59 and Resident 60's chart was reviewed, and a modification was made to their MDS to reflect the correct diagnosis. · Resident 59 and 60 were not affected by the alleged deficient practice. **II. The facility will identify other residents that may potentially be affected by the practice.** · Other residents in the facility with the diagnosis for serious mental illness are being reviewed to ensure the MDS assessment is accurate. Modifications will be completed as necessary. **III. The facility will put into place the following systematic**	

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	2. On 2/9/23 at 11:28 a.m., Resident 60's medical record was reviewed. The diagnoses included, but was not limited to other depressive episodes, psychotic disorder with delusions due to known physiological condition, anxiety disorder due to known physiological condition, and mood disorder due to known physiological condition with depressive features. Resident 60's medication orders included but were not limited to donepezil 5 mg tablet once a day for vascular dementia with behavioral disturbance, duloxetine 60 mg capsule, delayed release, once a day for mood disorder due to known physiological condition with depressive features and duloxetine 30 mg capsule, delayed release once a day for mood disorder due to known physiological condition with depressive features. A current care plan, dated 11/11/22, indicated Resident 60 had a psychotic disorder diagnosis with delusions and visual hallucinations due to known physiological condition. He had delusions and hallucinations which were distressful to him, such as believing facility was built on his home, believing he could care for self and wife, believing he did not need to utilize a wheelchair, believing he could drive, and believing there were bears and lions in the field behind the facility which may attack family and staff. Resident 60's most recent annual, comprehensive MDS assessment, dated 4/29/22, section A1500 Preadmission Screening and Resident Review (PASRR) indicated "no" for "Is the resident currently considered by the state level II PASRR process to have serious mental illness and or intellectual disability or a related condition?" Section A1510 had no boxes checked for serious		**changes to ensure that the practice does not recur** · The MDS team is being educated regarding accuracy of assessments. **IV. The facility will monitor the corrective action by implementing the following measures.** · The MDS coordinator, or designee, will review 5 completed MDS assessments to ensure accuracy weekly for 12 weeks, then monthly for 12 months for a total of 12 months of monitoring. · The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date:** 3/19/23	

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	mental illness conditions. Resident 60's PASRR Level I screen, dated 10/18/21, indicated Resident 59 had serious mental illness but was not required to have a Level II evaluation due to a progressed neurocognitive disorder of dementia. The company for PASRR screening outcome explanation page indicated "...About the PASRR: Federal law requires that every person be screened before they are admitted to a Medicaid-certified nursing facility to see if they have a 'PASRR' Condition of any one of the following: a mental illness, an intellectual disability or related condition. This is called a Level I screening...Since this evaluation shows you have a 'PASRR Condition', if you admit to a Medicaid-certified nursing facility, or if you are currently in a Medicaid-certified nursing facility, the facility will need to document your PASRR Condition in the Minimum Data Set (MDS) assessment record. The facility should mark yes for question A1500 on the MDS, 'Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?' Also, your specific PASRR condition(s) should be checked in question A1510, 'Level II Preadmission Screening and Resident Review (PASRR) Conditions...." On 2/10/23 at 10:34 a.m., during an interview, Social Services 15 indicated mental health diagnoses were not marked on the MDS section A1500 and A1510 for Residents 59 and 60 because they did not qualify for a level II assessment, due to dementia diagnoses as their primary conditions. He did not believe the serious mental illness diagnoses were listed on the MDS if the resident			

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	was not required to have a Level II assessment, due to dementia as a primary diagnosis. On 2/9/23 at 2:11 p.m., the Administrator provided pages A-19 and 20 of the RAI (Resident Assessment Instrument) Manual, version 3.0, dated October 2018. This document indicated, "...Steps for Assessment: 1. Complete if A0310A= 01, 03,04 or 05 (Admission Assessment, Annual Assessment, Significant Change in Status Assessment, Significant Correction to Prior Comprehensive Assessment). 2. Review the Level I PASRR form to determine whether a Level II PASRR was required. 3. Review the PASRR report provided by the State if Level II screening was required...." 3.1-31(i)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to document and follow up on non-pressure skin impairments and failed to address new onset acute pain promptly resulting in a change of condition for a resident for 1 of 3 residents reviewed for Urinary Tract Infections (UTIs). (Resident F) Findings include:	F 0684	**Cumberland Trace requests paper compliance for the following deficiencies. This plan of correction is to serve as Cumberland Trace's credible allegation of compliance.** **Submission of this plan of correction does not constitute**	03/19/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 2/8/23 at 9:50 a.m., Resident F was initially observed with a family member who was visiting. Resident F was pleasantly confused, and unable to answer simple questions. Her family member indicated she did not talk much anymore, so it was important to watch for changes in her behaviors. She had some recent medication adjustments and had been treated for a UTI, and it seemed that Resident F had settled down a lot more. On 2/13/23 at 10:58 a.m., a record review was conducted for Resident F. The most recent Minimum Data Set (MDS) assessment was a discharge MDS, dated 1/19/23, which indicated she was moderately cognitively impaired and made poor decisions. Resident F had a comprehensive care plan initiated 5/17/22 which indicated she was at risk for skin breakdown related to incontinence and decreased bed mobility. However, the care plan lacked revision to include person-centered approached or interventions to address her behaviors which resulted in the above injuries. A nursing progress note, dated 9/8/22 at 9:58 p.m., indicated the nurse had gone to give Resident F her evening medications. Upon entering Resident F's room, she was laying on her bed with no pants on so that the back of her legs could be seen. The nurse noted, "bruising to Resident right outer and back of knee." Resident F grimaced and groaned and indicated she was in pain. Resident F was unable to indicate where her pain but continued to grimace and groan. The nurse indicated she gave Resident F some Tylenol and indicated she would report the area to the incoming nurse. The record lacked documentation the Physician		**an admission by Cumberland Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident F was assessed, and comprehensive care plans were revised to include to address behaviors, non-verbal signs of pain, and history of UTIs. **II. The facility will identify other residents that may potentially be affected by the practice.** Other cognitively impaired residents are being assessed to determine if their person-centered care plans need revised to include interventions related to pain, behaviors, and management of medical conditions. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur**	

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	155836	A. BUILDING 00 B. WING	02/16/2023

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	was notified. The record lacked documentation of the wound size, shape and/or measurements. The record lacked documentation of any follow up to the area. A nursing progress note dated 10/14/22 at 2:55 p.m., indicated, Resident F had been in a pleasant mood that shift with no behaviors present, however she did complaint of pain in her back, so she was given Tylenol. A nursing progress note dated 10/17/22 at 11:39 a.m., indicated, Resident F continued to complain of pain in her back, but Tylenol as needed was effective. A nursing progress note dated 10/18/22 at 2:15 p.m., indicated, Resident F still complained of pain in her back and the as needed Tylenol remained effective. The record lacked documentation the physician had been notified over the course of the 5 days that Resident F complained of back pain. By 10/19/22 at 2:28 p.m., Resident F was noted to be delusional as she attempted to talk people in the pictures of other resident's memory boxes. On 10/24/22 at 3:12 p.m., the results of Resident F's UA (urinalysis) were received, and she was started on Keflex, an antibiotic medication. There were several nursing progress notes which indicated new red, raised areas noted to Resident F's chest and hands: a. 10/24/22 at 7:38 p.m., " ...Resident noted red		The MDS coordinator will conduct an in-service for the interdisciplinary team to review procedures for development of a person-centered care plan. Licensed nurses will be re-educated on the change of condition policy to ensure prompt notification of the attending physician when residents have a new or change of condition. **IV. The facility will monitor the corrective action by implementing the following measures.** Administrator, or designee, will review 5 cognitively impaired residents to ensure person centered care is provided and care plans are updated with person-centered weekly for 12 weeks, then monthly for 9 months for a total of 12 months of monitoring. The DON or designee will monitor event charting for prompt physician notification of the change of condition daily for 4 weeks, weekly for 8 weeks, then monthly for 9 months for a total of 12 months of monitoring. The results of these reviews will be discussed at the monthly facility	

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	raise area to back, chest and both hands knuckles, denied pain ..." b. 10/24/22 at 9:18 p.m., " ...Red raised area to back, chest and knuckles, denied pain, resident also experiencing chills, afebrile [no fever] ...." There was no indication the physician was notified at the time the areas were identified, however the Nurse Practitioner, (NP) was in the following day on 10/25/22 at 12:44 p.m., and indicated, " .... She [Resident F] has a few red areas to her right hand with appearance of abrasion or light bruising. No rashes noted. Discussed rash with facility staff and current staff denies any rash to arms, chest, abdominal, or back. Staff reports resident is taking medication for UTI. Staff also reports red areas on hand are mostly likely from resident hitting wall or objects when she is mad .... On 10/25/22 Resident F had a change of condition and was noted to get increasingly lethargic through the day. At 1:44 p.m. she was noted to be lethargic and had a poor appetite, despite the antibiotic for her UTI. At 9:54 p.m. that evening, Resident F was in bed and noted to be very lethargic with a poor appetite and only took sips of fluid, and by 11:53 p.m., she remained lethargic, so a new order was obtained to send her to the ER. On 10/26/22 at 10:57 a.m., Resident F returned from the hospital, still very lethargic but had new order for Cephalexin, a stronger antibiotic. During an interview on 2/14/23 at 10:09 a.m., the CM-UM (Cherished Memories Unit Manager) indicated, at the time of the bruise to the back of her knee was noted she had been experiencing a lot more agitation and aggression. She had an		Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date:** 3/19/23	

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	increase of behaviors and would hit or kick and had a tendency to get physical. She would hit or bang on the glass doors too. The CM-UM indicated the nurse who identified the bruise to the back of her knee, should have notified the physician and opened an event for follow up. As for her UTI, a urinalysis was attempted but it came back contaminated, so a second sample was collected. It came back positive for a UTI on 10/24/22 which would have been 10 days after her initial complaints of pain. She was started on an antibiotic but became lethargic in the following days and needed to be sent to the hospital. She did come back from the hospital with a diagnosis of a UTI and was started on a new antibiotic. Resident F was non-verbal, so it was important to monitor her behavioral symptoms and overall demeanor. When the CM-UM contacted Resident F's family member, she was informed that Resident F, "will plummet fast from any type of infection, she had always been that way." Resident F's comprehensive care plan was reviewed and lacked documentation or revision to include person-centered approached or interventions to address her history of UTIs. On 2/13/23 at 10:45 a.m., the Administrator provided a copy of current facility policy titled, "Change in a Resident's Condition or Status," revised 10/2010. The policy indicated, "Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status ... 1. The Nurse Supervisor/Charge Nurse will notify the resident's attending physician or On-Call Physician when there had been ... a discovery of injuries of an unknown source ... a significant change in the resident's			

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	physical/emotional/mental condition, a need to alter the resident's medical treatment significantly ...." On 2/13/23 at 10:45 a.m., the Administrator provided a copy of current facility policy titled, Comprehensive Person-Centered Care Plans, revised 12/2016. The policy indicated, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident ...the comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes ... g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems ... 10. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. 11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. a. when possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers ...." 3.1-37			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, interview, and record review, the facility failed to prevent the potential for accidents when two residents, who were both at risk for wandering and elopement, were able to exit the secured memory care unit without staff knowledge or supervision for 2 of 8 residents reviewed for accidents (Residents F and E). B. Based on interview and record review, the facility failed to prevent the potential for accidents by not identifying specific risk factors and implementing person-centered interventions for a resident for 1 of 8 residents reviewed for accidents (Resident 84). Findings include: A1. On 2/8/23 at 9:00 a.m., a brief record review for Resident F was conducted and she was sampled for investigation due to her elopement off the CM unit in August 2022. Resident F was admitted to Cherished Memories (CM, a secured dementia care unit) on 5/16/22. She had diagnoses which included, but were not limited to, dementia with mood disturbances. An admission nursing assessment, dated 5/16/22, indicated no concern related to mood and behavior. A supplemental nursing admission assessment, dated, 5/16/22, included a 3-question Elopement Risk Assessment with the following instructions, "If the charge nurse answers any of the questions yes then the resident is at risk for elopement. If	F 0689	1) 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A. Residents F and E's safety has been maintained to prevent the potential for accidents. The keypad has been relocated and boundaries set near each exit using red tape markings on the floor. B. Resident 84 risk factors have been identified and person-centered interventions implemented. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken A. Residents residing in the facility have the potential to be affected by the alleged deficient practice. An audit was completed to determine to ensure safety has been maintained to prevent the potential for accidents for residents at risk for wandering and elopement. B. Residents residing in the facility have the potential to be affected by the alleged deficient practice. An audit was completed	03/19/2023

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	any of the assessment questions below are answered yes then the charge nurse will put interventions into place and document those interventions to prevent the resident from eloping. Those interventions might include Increase in staff monitoring (1:1 supervision or 15 minute checks), placing a wander guard, meeting with the resident or family to calm the resident or contacting the family and/or the director of nursing for successful interventions they have used in the past." Resident F was determined to be at risk for elopement as the first question, "Does the resident wander aimlessly?" was marked Yes. An Admission Care Plan was initiated on 5/16/22, which included but was not limited to the following: "Elopement safety interventions implemented for resident identified at risk for elopement" and included (but was not limited to) the following interventions, which were not person-centered or specific. a. "1:1 care provided" but without specification of who would provide 1:1 care, when the 1:1 care would be provided, or a determined amount of time the 1:1 care would be required. b. "15-minute checks" but without specification of who would complete the 15-minute checks, when the 15-minute checks would be provided, or a determined amount of time in which the 15-minute would be required. c. "Wander guard put into place" without specification of obtaining a physician's order, when or where the wander guard should be placed. On 2/9/23 at 8:58 a.m., Resident F was observed in her CM unit. She paced back and forth from the dining room to the Nurses' station and made her		to ensure specific risk factors were identified and person-centered interventions implemented 3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur Licensed associates educated on the elopement policy and identifying risk factors and implementing person-centered interventions. Will be educated upon hire and annually. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place A. DON or designee will audit 5 residents daily to ensure safety has been maintained to prevent the potential for accidents for residents at risk for wandering and elopement. Audits will continue weekly x 12 weeks, monthly for 8 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee B. DON or designee will audit 5 residents daily for 30 days to	

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	way to the CM main entrance. There was a large squared off area marked with red tape on the floors in front of the double glass doors. There was a main door from the outside, which opened into a secondary entrance which was a full glass locked door. Resident F approached the door and stood by the window and looked outside into the parking lot, then paced back into the activity lounge, dining room, and up and down the hall. On 2/8/23 at 9:50 a.m., Resident F's family member was visiting and interviewed at that time. He indicated Resident F had a harder time adjusting to the move from her previous nursing home to CH. She would often get anxious and pace, sometimes looking at family pictures would help her calm down. On 2/13/23 at 10:58 a.m., a record review was conducted for Resident F. The most recent MDS (minimum data set) assessment was discharge MDS dated 1/19/23 which indicated she was moderately cognitively impaired and made poor decisions. Resident F's nursing progress notes were reviewed: On 7/11/22 at 3:06 p.m., a new order was received for a Gradual Dose Reduction (GDR, an intentional and tapered attempt to recuse a medication) of Resident F's Seroquel (an antipsychotic medication). From 7/11/22-7/15/22, Resident F had an increased behaviors of refusing to eat, pacing the unit, she became verbally aggressive with her peers, and had an increase in paranoia and anxiety. Therefore, the GDR was failed, and her original dose of Seroquel was resumed.		ensure specific risk factors were identified and person-centered interventions implemented. Audits will continue weekly x 12 weeks, monthly for 8 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee 5) Date corrective action will be completed: 3/19/23	

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On 7/29/22 at 10:25 a.m., a progress note indicated, Resident F had been sitting in the dining room when another resident approached her and initiated an altercation, she made contact with Resident F by hitting her in the face. The residents were immediately separated and assessed for injuries. There were none.

On 7/30/22 at 2:31 p.m., a progress note indicated Resident F did not remember the altercation and showed no signs of pain.

On 8/2/22 at 1:28 p.m., a Social Service (SS) note indicated Resident F had no recollection of the altercation and showed no signs or symptoms of psychosocial stress.

On 8/6/22 at 6:21 p.m., Resident F was brought back to the CM unit by a Certified Nursing Assistant (CNA) from another unit. Resident F was alert, with confusion. The CNA stated Resident F was outside in the parking lot when she drove up. A head-to-toe assessment was completed with no findings and proper notification were made. Resident F had no memory of being outside.

An Elopement Event was opened on 8/6/22 at 8:18 p.m., and indicated the following: "Did resident exhibit any of the following behaviors prior to elopement? Other was checked and indicated, "Resident was aggravated at other resident on unit for keeping on calling her, her mom," and the immediate intervention was that Resident F was returned to the CH unit.

A State Reportable Incident #395 indicated on 8/6/22, Resident F exited the unit behind a visitor. Staff saw her in the parking lot, and she was

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	returned to the unit without incident. Resident F was immediately assessed, and proper notifications had been made. Further, the CM entrance doors were inspected to ensure the locking mechanisms were functioning properly and staff were educated to ensure doors close and latch when visitors enter. The Administrator (ADM) sent a text-blast on 8/6/22 at 7:37 p.m. which indicated, "Staff, always ensure that doors on Cherished Memories close and latch completely before turning your attention away. Respond to this message with your name to acknowledge you've read and understood." A new Elopement Risk Assessment was completed on 8/8/22 with was the same 3-question Elopement Risk Assessment and included the following instructions, "If the charge nurse answers any of the questions yes then the resident is at risk for elopement. If any of the assessment questions below are answered yes then the charge nurse will put interventions into place and document those interventions to prevent the resident from eloping. Those interventions might include Increase in staff monitoring (1:1 supervision or 15 minute checks), placing a wander guard, meeting with the resident or family to calm the resident or contacting the family and/or the director of nursing for successful interventions they have used in the past." Resident F was determined to be at risk for elopement as all three questions were marked, "yes." A formal, all-staff Elopement Education in-service was provided on 8/8/22, (but did not indicate who provided the education.) A copy of the Power-Point presentation, titled, "Elopement," was included and reviewed. Of the 29 slides, none			

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	of the material addressed supervision of the entrance/exit of visitors/vendors. The Assistant Director of Nursing (ADON) submitted a written witness statement dated 8/6/22. Her statement indicated, " ...When [CNA 27] found her [Resident F] she was walking. CNA 27 stated that she was on her way to the Heritage neighborhood when she saw her. She said that she looked confused and was crying ... the only behavior that I had from her earlier before dinner was, she got agitated at [a peer] because [the peer] kept coming up to her stating that she was her mother ... She does not have a sunburn. When she was brought back to the unit her head-to-toe assessment and pain assessment was completed. Vitals obtained and fluids and food offered and accepted." The record lacked documentation of updated care plans related to her behaviors and history of elopement until 11/7/22. A care plan, initiated 11/7/22, indicated Resident F had "behavioral symptoms," and was at risk for elopement related to, wandering, exit seeking, history of elopement from home or a facility, expressing the need to go home or leave. Interventions for the plan of care, initiated 11/7/22 included, "increase staff monitoring as needed, redirect resident if wandering in unsupervised areas and when resident begins to wander, provide comfort measures for basic needs (e.g., pain, hunger, toileting, too hot/cold, activities etc.)." A care plan, initiated on 11/11/22, indicated Resident F had "behavioral symptoms," due to her diagnosis of dementia. The care plan indicated, "[Resident F] has a Dementia in other			

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	diseases classified elsewhere with behavioral disturbances diagnosis and at times exhibits the following signs and symptoms: wandering, exit seeking, history of elopement from home or a facility, expresses the need to go home or leave." All the interventions for this plan of care were also initiated on 11/11/22 and included, but were not limited to, "Encourage time outside or near a window to expose resident to day/night to promote regular sleep pattern," and "New or worsening behaviors will be monitored, and new interventions will be considered in order to promote the highest level of quality of life for this resident." During a follow up phone interview on 2/10/23 at 11:37 a.m., Resident F's family member indicated, he had been made aware that Resident F has exited the unit and was found outside in the parking lot trying to get into cars. Although he had not been given a lot of details about the incident, he was under the impression that Resident F was near the door when a visitor came in and she slipped out behind them. It was a really warm day so when they brought her in, she was a little dehydrated, but they gave her some water and she seemed fine. The family member indicated he was not surprised that a visitor would have let her out because she did not use a wheelchair or a walker. Her hair was longer than most and not so grey, so she probably looked more like a visitor herself than a resident. During a phone interview on 2/10/23 at 2:36 p.m., a second member of Resident F's family was interviewed. The family member indicated, she could not recall what time she got the call, but the facility called to let her know, Resident F had been found outside, off the CH unit. While the family member had no complaints about the facility, she			

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	indicated she was quite concerned at the time of the incident because it was a very hot day, and Resident F had been wearing a sweater. When they found her in the parking lot she was upset, crying and tried to get in other people's cars. The family member indicated, she thought this biggest issue was Resident F could see an exit, through the glass doors, and just thought she could go out when she wanted, whereas, at her previous facility, the exit doors were not glass, and the residents could not see an exit directly to the outside. Weather/temperature archives, found on the National Weather Service website: https://www.weather.gov/wrh/Climate?wfo=ind indicated the high for 8/6/22, had been 91 degrees Fahrenheit, (F) with an average temperature of 82 degrees F. During an interview on 2/10/233 at 1:48 p.m., CNA 28 indicated she had worked with Resident F since her admission back in May. It took a while for her to get adjusted, and there were some pretty rough days. Her biggest behavioral symptom was that she gets agitated, usually the more agitated she is, the quicker and more determined her pacing became. During an interview on 2/10/23 at 1:54 p.m., the ADON indicated she was covering as the floor nurse that evening and it was right around dinner time. She, and the other staff had been busy in the dining room getting residents seated and served when she noticed some family visitors at the CH main entrance door. To her recollection, the ADON did not remember seeing Resident F near the door as she went to let the family in. At that time, the numbered keypad had been located behind the nurses' station. The ADON went			

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	behind the nurses' station, entered the passcode and the visitors were able to enter. The ADON knew the visitors, and that they were coming to eat with their loved one, so she went back into the dining room to assist the resident to the visitor so they could go to their room. Without her knowledge, apparently, Resident F must have slipped out as the visitors entered. During an interview on 2/10/23 at 2:44 p.m., the ADM indicated, he was familiar with Resident F and until the incident, there had been no indication she was a "flight risk." Nursing staff called him that evening and told him that Resident F had been found in the employee parking lot. In review of the security video footage, Resident F was observed to exit the doors behind the visitors who entered. Unfortunately, it had been in the blink of an eye and at the perfect timing, just as the ADON turned her back to come back around from the nurses' station, and the visitors entered, Resident F was able to catch the door before it latched. After the incident the ADM indicated he sent a text-blast that night advising all staff to ensure locked doors are closed and latched behind visitors, and the CM entrance door was inspected to ensure it was functioning properly and no abnormalities were noted. Additionally, and all staff in-service on elopement was provided in the following days, but he could not recall if the in-service specifically mentioned monitoring locked doors and ensuring they closed and locked behind visitors so that at risk residents could not follow them out. A2. On 2/8/23 at 3:18 p.m., Resident E was observed off the CM unit, with a family visitor. At that time, they agreed to an interview, and entered the conference room. As they moved into the room, Resident E was observed to be pleasant and			

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	smiling but confused, and he asked questions like, "where are we going?" "Have I been here before?" He was seated in a wheelchair (WC) but was able to independently propel himself into the room. The family member was seated beside him, and he asked, "What's this about?" A Wanderguard was noted to be secured to the left handrail of his WC. When asked about the device, his family member indicated, the wanderguard had been placed after an incident several months ago when he somehow got off the CM unit and was found at the front entrance of the facility. This had been back in November, and thankfully it was a warmer day with no rain or bad weather. The family member indicated she was quite concerned that he had gotten out and made it that far. The nursing staff knew he liked to go outside and had attempted to get out multiple times before which was why he was moved to memory care. She did not know how long he had been unaccounted for, he left the CM entrance door, and got all the way to the front entrance of the building which was quite a ways for someone in a wheelchair. The family member indicated they were told he must have followed someone out the door which was not a surprise because he loved the outdoors and would prefer to be outside anytime rather than be inside. He was always asking about going outside and when his wife visited, before he moved to CM, that's what they would do. On nice day they would go sit outside together. During an interview on 2/9/23 at 3:49 p.m., a second member of Resident E's family member indicated, the Administrator called her to inform her Resident E had gotten off the CM unit and had been found at the front entrance. She indicated she was not surprised that's where they found him since he liked to sit outside as often as he could, and always looked for way to get			

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	outside. While she had no complaints about the facility or Resident E's care, she was quite concerned that he had made it outside without anyone knowing or supervising and she was worried to think about what could have happened. On 2/10/23 at 10:47 a.m., Resident E's medical record was reviewed. The most recent MDS assessment was a quarterly MDS assessment, dated 1/4/23, which indicated he was severely cognitively impaired with a BIMS (brief interview for mental status) score of 4. As noted above, Resident E was a long-term care resident who resided on the secured CM unit with a diagnosis of unspecified dementia. Before this however, he had lived in the main population on the Ambassador Square neighborhood. A review of his nursing progress notes revealed around the time of May 2022, he began to have increased confusion and began exhibiting signs of poor safety awareness. On 5/5/22 at 12:50 p.m., Resident E was confused about some boxes which were in his room. He stated, "I am frustrated and want to go home. My wife has my phone, and I don't know what is going on." On 5/16/22 at 11:34 a.m., a note indicated Resident E could become frustrated at times with changes. On 6/9/22 at 4:09 p.m., a social services follow up note indicated, "follow up Resident sitting out front independent: Staff shared concerns regarding resident sitting out front on bench independent. Resident sits out front and waits on his wife. Wife contacted, and she is okay with him sitting out front.			

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On 6/14/22 at 9:01 a.m., the Receptionist called Resident E's unit and said he had been sitting outside but she could no longer see him from the front desk. The receptionist was advised it was okay per the DON and ADM that resident was ok to go outside by himself.

On 6/18/22 at 3:30 p.m., a nursing note indicated, Resident E was noticed to be talking on the phone with his wife but appeared to be having uncontrollable jerking in both arms to the point he was unable to hold his phone. The nurse went to him and picked up the phone to talk to his wife and see what was going on. Resident E's wife explained that he had been taken outside before 2:00 p.m., and apparently he was outside for over an hour. Upon assessment, he was very confused, more than usual, unable to stand without assistance and his skin was warm and wet with sweat. The nurse applied a cool towel to his forehead. His vital signs were taken and within normal limited except a slightly elevated temperature of 99 degrees. (The note lacked documentation that the physician was notified).

Later that evening on 6/18/22 at 5:50 p.m., Resident E's wife had come back to eat dinner with him, and he was back to his normal self.

Weather/temperature archives, found on the National Weather Service website indicated the high for 8/6/22, had been 80 degrees Fahrenheit, (F) with an average temperature of 75.5 degrees F.

On 6/20/22 at 4:44 p.m., a social service note indicated, a follow up conversation was held with Resident E's wife, after Resident E had been observed by staff (off the sidewalk) sitting in the grass in his wheelchair. His wife was informed

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	Resident E would no longer be able to go outside independent and would have a Wanderguard placed on his wheelchair. The wife stated, Resident E would not like that. On 6/23/22 at 3:03 p.m., the Receptionist called Resident E's nurse to let them know that Resident E was at the front desk and wanted to go outside by himself. When the Receptionist told him to wait and she would see if she could find someone to go out with him, he became loud and frustrated. The Director of Nursing (DON) and Social Service (SS) came out to help calm him down. Staff was unable to calm him, until the Scheduler stated that she would be glad to sit outside with him. On 6/23/22 at 6:09 p.m., a nursing note indicated, "Resident with several outdoor issues this date." Resident E wanted to go outside and staff accompanying him each time. However, with elevated temperatures, resident non-compliant with having short/small trips outside. It was reported that Resident E was attempting to follow other family members and staff outdoors when near the exit doors. His Wanderguard remained in place and was functioning properly. His wife was out of town at that time, and indicated she understood the difficulty because he, "loves to be outside." On 6/24/22 at 10:04 a.m., Resident E was at the front desk and wanted to go outside. The Administrator was able to redirect him back to his unit to sit on the unit courtyard. Later that day, on 6/24/22 at 2:52 p.m., another resident's family member arrived and entered the facility. While the visitor was walking in, Resident E attempted to go out through the door. He was redirected back inside.			

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On 6/27/22 at 10:57 a.m., a nursing note indicated, "Resident pushing on door by nurses' station a couple of times this morning."

On 7/1/22 at 3:15 p.m., a SS note indicated a care plan meeting was needed due to Resident E's increased confusion and wandering. Over the weekend he had wandered to the AL (assisted living) side and was pushing on the doors aggressively demanding to be let out. Today staff reported he went to the therapy gym and was pushing on the door and set the alarm off, his exit seeking, and wandering had increased.

On 7/6/22 at 9:58 a.m., Resident E's family was made aware of an upcoming bed availability on CM unit.

On 7/11/22 at 11:20 a.m., Resident E was transferred to CM unit.

An Elopement Risk Assessment was dated 8/8/22. The 3-question assessment indicated Resident E was not at risk for elopement as none of the questions were marked, "yes," even though his transfer CM was in direct response to his increased, unsafe attempts to exit the facility.

A comprehensive care plan for Resident E's risk of wandering or elopement was not initiated until 11/5/22, 4 months after he moved to a secured unit. The care plan indicated, he at risk for elopement related to wandering, exit seeking and a history of elopement from unit. Interventions for the plan of care included, "increase staff monitoring as needed, redirect [Resident E] when he attempts to leave the Unit and when [Resident E] begins to wander, provide comfort measures for basic needs pain, hunger, toileting, too hot/cold,

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	and activities." The care plan lacked documentation of resident-centered redirection/diversional activities to his preference and desire to go outside when the weather was permitting and lacked documentation of his previous attempts to follow staff/visitors out of exit doors. A nursing progress note, dated 11/4/22 at 4:38 p.m., indicated, Resident E was found outside near the front entrance of the facility. He was escorted back to the CM unit, and a head to toe assessment was completed with no issues noted. His Wanderguard was in place and functioning and he was placed on 15-minute checks. Later that evening, a note timestamped at 10:05 p.m., indicated Resident E remained on 15-minute checks, and he was wandering the unit but easily redirected. A State Reportable Incident #404 indicated, on 11/4/22, Resident E exited the unit behind visitors. Staff saw the Resident outside of the entrance and returned to unit without incident. Staff were educated to ensure doors close and latch when visitors enter. A formal all-staff Dementia Education in-service was provided, (but did not indicate who provided the education.) A copy of the Power-Point presentation, titled, "Elopement," was included and reviewed. Of the 29 slides, none of the material addressed supervision of the entrance/exit of visitors/vendors. During an interview on 2/10/23 at 2:03 p.m., the CM Unit Manager, (CM-UM) indicated, Resident E came to us after being on Ambassador because			

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	he became more and more confused and started to try to exit the building unsafely. He is a continuous, "can I go outside, can I go outside, can I go outside," he repeats it over and over. He would go to the door and wait; he watched the doors like a hawk. The CM-UM indicated she was not on duty the night of the incident but when she came in and got report was informed about what happened. The company who refilled the units 10L (liter) oxygen tank we in and out of the door while the nurses were completing shift change and giving report. Resident E was able to catch the door behind the Oxygen Technicians and let himself out. After that incident, the numbered keypad to unlock the door was moved out from behind the nurse's station and placed directly beside the door, and the CM-UM put down bright red tape in front of the door to serve as a "no-standing zone," to remind staff no to let residents stand close to the doors. Even though Resident E had a Wanderguard placed on his WC, the alarm would not have sounded because there was no alarm on the CM main entrance since the door are always locked. The Wanderguard system was utilized for the rest of the building. During an interview on 2/10/22 at 2:29 p.m., Licensed Practical Nurse (LPN) 29 indicated she had been the one who found Resident E at the front entrance when she pulled up to park. She was familiar with the resident and knew he lived on the memory care unit, so she took him back inside. Resident E always asked to go outside, and always waited by the doors. Weather/temperature archives, found on the National Weather Service website indicated the high for 11/4/22, had been 76 degrees Fahrenheit, (F) with an average temperature of 63.5 degrees F.			

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	During an interview on 2/10/22 at 2:50 p.m., the Administrator indicated Resident E's elopement was a similar situation to Resident F's elopement. A visitor had been in or out of the doors and he was able to catch the door behind them and let himself out. When asked how that was possible, if Resident F had gotten out by following a visitor, then why or how had Resident E been able to do the same thing just a few months later, the Administrator indicated, "that was the same question I had." The CM unit doors had been checked to make sure they were functioning properly, and the staff had been in-services. The CM entrance keypad was moved, and a no-stand red tape zone had been implemented. On 2/10/23 at 1:20 p.m., the ADM provided a copy of current facility policy titled, "Elopement Risk Policy," dated, 12/1/14. The policy indicated, "This policy serves as guidance to the CarDon Communities on identifying and initiating a plan of care for residents with history of elopements and/or risk for elopement ... Elopement is when a resident leaves the premises without authorization (i.e., without a discharge order or leave of absence order) and/or without the supervision to do so. Resident elopement is defined as a cognitively impaired resident who was found outside the facility and whose whereabouts had been unknown ... Residents will be identified for elopement risk by the following: nursing assessment upon admission and new or worsening behavior event of wandering, exit seeking, or elopements after admission to the community ... if the resident is determined to be at risk for elopement the community will initiate a plan of care that will ensure the residents safety, the plan may include interventions such as placement of a wandering guard alarm device, 11 Staff monitoring or placing the resident on a			

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	secured unit ...." On 2/13/23 at 10:50 a.m., the ADM provided a copy of a current, but undated document titled, "Memory Care Programming, The Neighborhood Principles and Practices." The manual indicated; its purpose was to serve as a guide for the care of a specialized population of residents with a primary diagnosis of dementia-related illness. "Every resident's journey will differ and require community associates to adapt to principles and practices at time within this programming outline ... it is the policy of The Neighborhood to provide residents with dementia disorders a therapeutic environment. This safe and structured environment meets the physical, emotional, social, and spiritual needs throughout the disease process ... Wandering describes the behavior that appears to be moving about aimlessly, but in fact is purposeful. Reasons resident wander: physical or psychological need not being met, looking for someone or something, response to environment irritants or side effects of medications ... Exit seeking is goal directed behavior that involves a plan and action to leave the community. This type of behavior can cause harm and be detrimental if the resident leaves the community. Reasons resident exit seeks: Resident believes they have a responsibility they need to meet, or the resident is confused and/or angry they are in the facility being "held hostage," ... Our overall environment is designed and adapted to promote safety while maintaining independence and well-being. B. On 2/9/23 at 10:50 a.m., Resident 84 was observed. She briskly walked, without any assistive devices, around the main dining room and nurses' station and in/out of the activity lounge. She was pleasantly confused and smiled at those who passed her. At that time, her room			

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	was observed. Although her room was clean and well lit, there was a Styrofoam cup of water on her bedside table. Some droplets of spilled water were observed on the table-top, and the lid to the cup was off, straw still in the lid, which laid on the tabletop next to the cup. On 2/9/23 at 10:22 a.m., Resident 84's medical record was reviewed. The most recent MDS assessment was a quarterly MDS assessment, dated 11/29/22, which indicated she was severely cognitively impaired with a BIMS score of 3. She was a long-term-care resident who resided on the secured CM unit. She admitted to the facility on 8/23/22 with diagnoses which included but were not limited to, unspecified dementia and overactive bladder. A nursing progress note, dated 10/31/22 at 11:54 p.m., indicated, Resident 84 walked towards the nurses' station at approximately 11:15 p.m. She was nude and carried a bed sheet. She stated she had fallen but was unable to state when or where she fell. Upon entering her room, the lights were all on and there was a liquid substance on the floor. She had sustained a skin tear which measured 1.5 cm (centimeters) long by 0.7 cm wide which had already dried. Resident 84 was tearful because she could not recall what happened. A corresponding Fall Event dated 10/31/22 was opened but did not indicate the floors of her room had been wet, but that she had been incontinent of urine. New orders were obtained to complete a set of vital signs every shift for 72 hours. An IDT (interdisciplinary team) Observation was dated 11/1/22 for an unwitnessed fall but did not include the date of the fall which was being			

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	reviewed. Interventions from the observation indicated, "staff to round on resident during the night," but did not specify what night, how often, or for what duration of time. She had a comprehensive care plan initiated 8/29/22 which indicated she was at risk for falls related to her diagnoses of dementia, her cognition and medication regiment. An intervention was added on 11/1/22 for staff to complete hourly rounds during the night, but again, did not specify any duration of time to conduct the rounding, as the frequency was left blank. On 12/30/22 Resident 84 tested positive for COVID-19 and was placed in her room in isolation. A nursing progress note, dated 1/2/23 at 8:42 a.m., indicated a CNA notified the floor nurse that Resident 84 was found lying on the floor near her bed. There was water all over the floor near the bed, close to where the resident was found. Upon assessment a bruise was noted on her left lower back. A corresponding Fall Event, dated 1/2/23 at 8:39 a.m., indicated Resident 84 had an unwitnessed fall. Her floor had been wet and she sustained a bruise to her lower back. Neuro checks were initiated.An IDT Observation was dated 1/2/23 at 12:57 p.m. and indicated Resident 84 had an unwitnessed fall. The root cause was determined to be that she had dementia and forgot to call for help with ADLS (activities of daily living), and the intervention put in place was a "call before you fall" sign which was placed in her room			

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	and in her bathroom. A nursing progress note dated 1/2/23 at 5:30 p.m., indicated Resident 84 was found on the floor with her head wedged between her recliner and the wall. A skin tear was noted on her left arm above her elbow. Her brief was down to her ankles, and she was unable to say what happened. 911 was called and Resident 84 was transferred to the ER for further evaluation and treatment. The corresponding Fall Event, dated 1/2/23 at 5:20 p.m., indicated Resident 84 had an unwitnessed fall in her room next to her bed. She had sustained a skin tear and was incontinent of bowel at the time of the fall. An IDT Fall Observation, dated 1/4/23 at 9:19 a.m., indicated Resident 84 had an unwitnessed fall. The root cause was determined to be the same as her previous fall that morning; she had a diagnosis of dementia and did not remember to ask for help with ADLs. Upon her re-admission, she was being treated for a urinary tract infection (UTI). A nursing progress note, dated, 1/3/23 at 2:00 a.m., indicated, Resident 84 returned from hospital with sutures to her left forearm and a diagnosis of a UTI and had new orders for an antibiotic. Her fall risk comprehensive care plan was revised on 11/423 to include an intervention that Resident 84 was being treated for a UTI. Her care plan lacked documentation or person-centered			

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	approaches to address Resident 84's habit or previous behaviors or dumping water on the floors.During an interview on 2/14/23 at 10:32 a.m., the CM-UM indicated, Resident 84 had two falls on the same day. At that time, she had recently tested positive for COVID-19 and had to be put in isolation in her room, and she had a really hard time in isolation. For whatever reason, the day she had two falls, she was "just out of it." She kept throwing her stuff away, moving her furniture around, she tried to put her shirt on her legs like pants. Unfortunately, there was no one available to sit and stay with her in her room, but she was on more frequent checks because of COVID-19. After the first fall in the morning, new signs were posted in her room to, "call before you fall." When asked if Resident 84 would be able to make sense out of the posted signs, or read the signs, the CM-UM indicated, she could read, but was unsure if it would have made sense to her given her altered mental status. When asked about Resident 84's previous fall in October, the CM-UM indicated, Resident 84 had a habit of dumping her drinks of splashing water on her floors. The CM-UM had taken her a cup of ice water for hydration pass. When Resident 84 self-reported her fall on the 31st, CM-UM went to her room and found water all over the floor, and her ice cup sat empty on her			

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	bedside table, with the straw next to it. Evidently, Resident 84 had spilled her water, but picked up the cup and straw. That's how they assumed she must have slipped and hit her lower back on the footboard of her bed, given the size and shape of the bruise. On 2/14/23 at 11:00 a.m., the ADM provided a copy of current facility policy titled, "Fall Prevention Policy and Procedure," dated 5/2016. The policy indicated, " ...A fall prevention program is essential to the provision of care to our residents. Falls are among the most frequent critical health problems for older adults living in long-term care facilities ... the purpose of this policy is to provide CarDon communities with best practices and evidence-based approaches to prevent falls and protect residents who are at risk for falling ... strategies to prevent falls are unique for each community. Each fall risk factor is unique for every resident ... strategies for interventions to prevent falls will be individual for each patient. Each section of the fall risk assessment tool should be considered, and staff should receive education pertaining to these risk factors to reduce falls ... Care plans are a vital part of the nursing process and serve as an individualized pathway used by all care givers. Fall risk care plans will be kept current by the IDT and other associates withing each community. Individualized			

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	interventions on the fall care plan will be duplicated onto care sheets to ensure care plan strategies are integrated into the health system ...."This Federal tag relates to Complaint IN00395302.3.1-45(a)			
F 0744 SS=E Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to ensure person-centered, individualized dementia care services were provided for a resident who desired outdoor activities which resulted in an increase of exit seeking behaviors and eventual elopement off a secured memory care unit for 1 of 6 residents reviewed for dementia care (Resident E); and the facility failed to ensure individualized dementia activities were implemented for 6 of 6 male residents who resided on the memory care unit (Resident E, 63, 13, 29, 56, and 22). Findings include: Resident E was a long-term care resident who resided on the secured memory care unit, Cherished Memories (CM). Resident E was transferred to CM after he began to have increased episodes of exit seeking and exhibited poor safety awareness and decision making when choosing to sit outside for long periods of time in hotter weather. He enjoyed time outside, and often sat outside with family members as often as possible. However, without	F 0744	**Cumberland Trace requests paper compliance for the following deficiencies. This plan of correction is to serve as Cumberland Trace's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Cumberland Trace or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** · Resident E, 63, 13, 29, 56,	03/19/2023

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	specialized person-centered activities which provided opportunities for Resident E to enjoy outdoor-style programming/activities, he had continued behaviors of attempting to exit the secured memory care unit, and eventually eloped off the unit. Cross Reference F689. During an interview on 2/8/23 at 3:18 p.m., Resident E's family member indicated, Resident E was a "big outdoors guy," and she wished there were more opportunities for the men to do outdoor activities or have more male-oriented activities. Resident E's family visited often and took him off the unit or outside it the weather was nice, but they were not sure if staff were able to do that for him when the family could not. On 2/15/23 at 9:13 a.m., Resident E was observed as he sat at the nurse's station and asked Certified Nursing Assistant (CNA) 29 if he could go outside. She shook her head no, and the CM-UM (CM Unit Manager) who was working at the medication cart indicated, it was too cold right then, but it was supposed to be a nice day, so after lunch around 1:00 they could go outside. On 2/15/23 at 1:00 p.m., Resident E received a visit from a family member when took him to his room to visit. When the family member left at 1:45 p.m., they indicated no one had come to ask if Resident E wanted to go outside. On 2/15/23 at 2:00 p.m., Resident E had been seated in the activity lounge, in the dark in front of the T.V. for a movie. His eyes were closed, and his head was lowered. Resident E was not offered an opportunity to go		and 22 care plans have been updated to reflect preferences and care needs. · Activities calendars have been updated to include individualized dementia activities including but not limited to male-centered and outdoor activities in secured courtyard. **II. The facility will identify other residents that may potentially be affected by the practice.** · Current residents that are on the locked dementia unit have the potential to be affected. **III. The facility will put into place the following systemic changes to ensure that the practice does not occur.** · The IDT team will review current residents residing on the memory care unit in the facility for individualized dementia activities to ensure that the appropriate measures are addressed on their specific care plan. **IV. The facility will monitor the corrective action by implementing the following measures.** · The administrator or designee will review 5 memory care residents' plan of care to ensure person centered care is provided and care plans are updated with person-centered weekly for 12 weeks, then monthly for 9 months.	

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	outside, even though the weather was favorable. During an interview on 2/15/23 at 2:15 p.m., the Activity Director (AD) indicated she was the certified AD for the entire campus, but the CM unit had their own AD who was also the unit's Social Service Director (SSD). The CM-AD (Cherished Memories Activity Director) oversaw CM specialized programming and activity planning. The AD deferred to her calendar and schedule and mostly just served as an overseer and event coordinator. She did not create or implement the CM activity calendar, and only reviewed it if requested the CM-UM. During an interview on 2/15/23 at 2:20 p.m., the CM-AD and CM-UM were both present. The CM-AD indicated she was in charge of both Social Services and Activities for the CM unit. She indicated she did not have an AD certification, but her background in social work helped guide her programming. As far as specific activities and programming for the men, they did not have anything in place at that time, because until recently there had not been many male residents who resided on the unit. Now that there were several, it was the plan to incorporate more male-oriented activities when the weather got nicer. When asked if there were an indoor male-oriented items/activities, the CM-AD indicated she only had one small red plumbers' box which contained several small PVC pipes. During an interview on 2/15/23 at 2:57 p.m., Resident E's family member indicated the family had talked with the CM-AD about getting some more men's group activities on the unit, but nothing had happened yet and because the weather was unpredictable he did not get to go outside often, but there were no accommodations		· The administrator or designee will review the activity calendar monthly for 12 months to ensure individualized dementia activities including but not limited to male-centered and outdoor activities are provided. · The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits.	

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	or modified "outdoor" style programming that could be adapted for inside use. During an interview on 2/16/23 at 11:56 a.m., Resident 56's family member indicated, Resident 56 had been on the CM unit since December of 2022. They indicated, for the most part Resident 56 was a quiet guy that kept to himself, but he would probably enjoy a men's group activity, or project. He used to work as an excavator, so small tools or building items may interest him. He was a harder guy to encourage to participate in activities because he was hard of hearing. Sometimes he would go to the Bingo activities, but because he could not hear very well, he never usually participated, but he sat and waited for someone else to win so he could get a piece of candy. During an interview on 2/16/23 at 12:05 p.m., Resident 63's family member indicated, Resident 63 had resided on the CM unit since October of 2022. The family member indicated, Resident 63 often said he missed talking to people, most of the resident on the unit did not make any sense and did not talk with him. The family indicated Resident 63 liked to go outside, but there were not many opportunities for that to happen. Resident 63 was a huge Colts fan, and IU Basketball. He served in the Air Force as a mechanical engineer and enjoyed carpentry when he was younger. He also like birds and bird watching, so having some outdoor magazines to flip through or small tool kits to tinker with would probably be really enjoyable for him. The family member indicated now that there were more men living on the unit, having male-oriented activities, tools or projects was something that should have already been in place. During an interview on 2/16/23 at 12:17 p.m.,			

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	Resident 29's family member indicated Resident 29 had been on the CM unit since July of 2022. For the first several months, after he got COVID he was a different person. It was as if COVID just "took him away, but then one day it was like he just woke back up." The family member indicated when he called and talked with Resident 29, he would say he was bored, but when asked what they could bring for him to do, he didn't have an answer. Now that he's doing better, he could probably benefit from some more specific things that appear to him. He used to tinker in the garage, he liked gardening, he liked reading the newspaper and used to subscribe to the Country Living magazine. The CM Activity calendars were reviewed for the prior three months, and while there were a variety of activities which were scheduled the same time every day to promote consistency and structure, the activities did not include general or specific "male-oriented" opportunities/projects. Some examples included, but were not limited to: a. Hallmark Movie Channel Movies, but nothing similarly themed for men. b. "I Love Lucy Marathons," but nothing similarly themed for men. c. Monday Manicures, but nothing similarly themed for men. On 2/13/23 at 10:50 a.m., the Administrator (ADM) provided a copy of a current, but undated document titled, "Memory Care Programming, The Neighborhood Principles and Practices." The manual indicated; its purpose was to serve as a guide for the care of a specialized population of residents with a primary diagnosis of dementia-related illness. "Every resident's journey will differ and require community associates to adapt to principles and practices at time within			

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	this programming outline ... our customized approach focuses on individuality, promotes choice, encourages continued participation in favorite activities, and celebrates accomplishments while it provides a supportive foundation. We strive to allow the resident's inner sense of self to be honored as they are offered opportunities to feel in control ... a secured outdoor space is created to feel like a backyard with patio and garden areas. This will allow our residents to spend time in nature and enjoy the beautiful weather with their friends and loved one ... 3.1-37			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of			

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	1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview the facility failed to ensure a narcotic medication was properly destroyed and kept in a safe double locked condition, inside the medication cart, after it was identified for destruction, for 1 of 1 random observations of medication storage. Findings include: On 2/10/23 at 9:15 a.m., during a random medication storage observation, on Renaisance Way, Licensed Practical Nurse (LPN) 17 was observed as she walked away from the medication cart and entered a random resident room. The medication cart was unlocked and the patient screen was open to Resident 206's Medication Administration Record. On 2/10/23 at 9:17 a.m., during the continued observation and an interview LPN 17 returned to the cart. The surveyor requested to observe the inside of the cart for a random medication storage observation. LPN 17 indicated to give her a few minutes because she had people waiting (for medications). She should not have left her cart unlocked. During a continous observation LPN 17 took pre-filled cups of medications from the medication cart and delivered them to multiple resident rooms. On 2/10/23 at 9:27 a.m., during the observation inside the medication cart, the top drawer	F 0761	**Cumberland Trace Health and Living requests paper compliance for the following deficiencies. This plan of correction is to serve as Cumberland Trace Health and Living's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Cumberland Trace Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** · Residents 206, 207, 208, 12, 198, and 204 had medication reviews to ensure they received the correct medications during the alleged non-compliant medication administration.	03/19/2023

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	contained a clear plastic medication cup, with 1/2 of a white oblong tablet inside. LPN 17 indicated it was 1/2 of a tramadol tablet (a narcotic pain reliever). The medication belonged to Resident 198. The resident had been given 1/2 tablet and the other half needed to be wasted. She had not found anyone to help her waste it. On 2/10/23 at 10:09 a.m., during an interview, the Director of Nursing (DON) indicated the medication cart should have been locked and the computer screen closed before LPN 17 walked away from the cart. Medications should not have been pre-set and narcotics should not have been left in the cart drawer until there was time to waste them. On 2/13/23 at 10:54 a.m., the Administrator provided a current, undated policy, titled "Drug Disposal." This policy indicated, "...Controlled drugs listed in Schedule II, III, IV, and of Controlled Drug Act are to be destroyed in the facility in the presence of the consultant pharmacist and DON or designated administrative nurse or DON and designated administrative nurse...." 3.1-25(n) 3.1-25(o)		· The narcotic was destroyed following the facility policy. · The nurse conducting the medication administration was immediately educated on proper medication administration and narcotic disposal. · Residents 206, 207, 208, 12, 198, and 204 did not suffer any ill affect related to the alleged deficient practice. **II. The facility will identify other residents that may potentially be affected by the practice.** · All residents in the facility have the potential to be affected by the alleged deficient practice. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur** · Nurses and QMAs were educated on 3/6/23 on proper medication administration and narcotic disposal. **IV. The facility will monitor the corrective action by implementing the following measures.** · The DON or designee will review 5 random medication administrations weekly for 8 weeks, 3 medication	

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	155836	A. BUILDING 00 B. WING	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CUMBERLAND TRACE HEALTH & LIVING COMMUNITY	1925 REEVES ROAD PLAINFIELD, IN 46168

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	Based on observation, record review, and interview, the facility failed to ensure medications were securely stored when medications were pre-set in cups inside the medication cart, the medication cart was left unattended, and unlocked during a medication pass for 1 of 2 random medication pass observations (Residents 206, 207, 208, 12, 198, and 204), and the facility failed to ensure a narcotic medication was properly destroyed and kept in a safe double locked condition, inside the medication cart, after it was identified for destruction for 1 of 1 random observations of medication storage (Resident 198). Findings include: On 2/10/23 at 9:15 a.m., during a random observation, on Renaissance Way, Licensed Practical Nurse (LPN) 17 was observed as she walked away from the medication cart and entered a random resident room. The medication cart was unlocked, and the patient screen was open to Resident 206's Medication Administration Record (MAR). On 2/10/23 at 9:17 a.m., during the continued observation and an interview LPN 17 returned to the cart. The surveyor requested to observe the inside of the cart for a random medication storage observation. LPN 17 indicated to give her a few minutes because she had people waiting (for medications). She should not have left her cart unlocked. On 2/10/23 at 9:17 a.m., LPN 17 took a cup of medications, that was pre-filled from the medication cart to Resident 206, in the resident		administrations weekly for 8 weeks, then 2 medication administrations per week for 36 weeks. · The DON or designee will review the narcotic disposal log 5 times weekly for 8 weeks, 3 times weekly for 8 weeks, and 2 times weekly for 36 weeks. · The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. **V. Plan of Correction completion date:** 3/19/23	

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	room. She left the computer screen open. On 2/10/23 at 9:20 a.m., LPN 17 returned to the medication cart and changed the MAR on the computer screen to show Resident 207's profile. She removed a cup of pre-set medications from the cart and delivered them to the resident room. On 2/10/23 at 9:22 a.m., LPN 17 returned to the medication cart and changed the MAR on the computer screen to show Resident 208's profile. She removed a cup of pre-set medications from the cart and delivered them to the resident room. On 2/10/23 at 9:24 a.m., LPN 17 returned to the medication cart and changed the MAR on the computer screen to show Resident 12's profile. She removed a cup of pre-set medications from the cart and delivered them to the resident room. On 2/10/23 at 9:25 a.m., LPN 17 returned to the medication and allowed an observation inside the cart. Resident 12's profile remained open on the computer screen. LPN 17 started to walk away from the cart and was requested to remain in the presence of the observation. On 2/10/23 at 9:27 a.m., during the observation inside the medication cart, the top drawer contained a clear plastic medication cup, with 1/2 of a white oblong tablet inside. LPN 17 indicated it was 1/2 of a tramadol tablet (a narcotic pain reliever). The medication belonged to Resident 198. The resident had been given 1/2 tablet and the other half needed to be wasted. She had not found anyone to help her waste it. On 2/10/23 at 9:29 a.m., a clear plastic cup of several different pre-set oral medications was observed as it sat on top of a box of wrapped			

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	medications, in the top of the box with a label, identified as the medication belonging to Resident 204. On 2/10/23 at 9:27 a.m., during an interview and observation inside the medication cart, the top drawer contained a clear plastic medication cup, with 1/2 of a white oblong tablet inside. LPN 17 indicated it was 1/2 of a tramadol tablet (a narcotic pain reliever). The medication belonged to Resident 198. The resident had been given 1/2 tablet and the other half needed to be wasted. She had not found anyone to help her waste it. Medications should have not been pre-set but that was how it had worked out "this morning." On 2/10/23 at 10:09 a.m., during an interview, the Director of Nursing (DON) indicated the medication cart should have been locked and the computer screen closed before LPN 17 walked away from the cart. Medications should not have been pre-set, and narcotics should not have been left in the cart drawer until there was time to waste them. The DON indicated the facility did not have a medication pass policy; they followed a licensed nurse med pass clinical skills validation. A copy of the document was provided for review, by the Administrator at 10:58 a.m., on 2/10/23. This undated document, titled, Licensed Nurse Med Pass Clinical Skills Validation indicated to bring the medication cart adjacent to the resident room, check the administration record, remove medication, for one resident, from the drawer and place in a cup. Close the MAR, computer screen, before walking away and make sure the cart was locked. Identify the resident. Any narcotics required the controlled substance documentation immediately, upon removal from the cart.			

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	3.1-25(b)(5) 3.1-25(n) 3.1-25(o)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §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 hand washing was completed correctly and wrapped utensils were not contaminated during lunch services for 10 of 17 resident served on the memory care unit. Findings include: On 2/7/23 at 12:15 p.m., the Environmental Services Director (ESD) was observed to serve lunch to Resident 33. Before setting her plate on	F 0812	**Cumberland Trace Health and Living requests paper compliance for the following deficiencies. The plan of correction is to serve as Cumberland Trace credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Cumberland Trace or it's management**	03/19/2023

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	the table, he moved her eyeglasses with his bare hand. He did not wash or gel his hands before gathering up a handful of wrapped utensils. He gave one to Resident 33, and then 8 other unidentified residents. On 2/7/23 at 12:23 p.m., the ESD was observed to wash his hands. He turned the contaminated faucet off with his bare hands and dried them with a paper towel. Immediately afterward, he provided lunch to Resident 38. During an interview, on 2/13/23 at 9:48 a.m., the Food Supervisor (FS) indicated staff should have washed their hands after touching a resident's personal property and hand washing should have been for 60 seconds. Then, to leave the water running, dry your hands, throw away that paper towel, and get a new paper towel to turn off the faucet. A document, titled, "Procedure #3: Handwashing/Handrub," was provided by the Clinical Specialist in placed of a hand washing policy, on 2/14/23 at 2:33 p.m.. A review of the procedure indicated after hand washing to, " ...rinse hands with water down from wrists to fingertips ...dry thoroughly with single use towels ...use towel to turn off faucet and discard towel ...Rationale ...prevents contamination of clean hands ...." 3.1-21(i)(3)		**company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute and agreement or admission of the survey allegations.** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** · The Environmental Services Director was immediately educated on appropriate hand hygiene practices during meal service. · Resident 33 nor the 8 other unidentified residents were not affected by the alleged incident. **II. The Facility will identify other residents that may potentially be affected by the practice.** Residents that are served by staff have the potential to be affected. **III. The facility will put into place the following systemic changes to ensure that the practice does not occur** Staff who assist with meal service will be reeducated to the professional standards for food service safety.	

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			IV. The facility will monitor the corrective action by implementing the following measures. The DON or designee will review 5 random meal services and ensure that the professional standards for food service safety are followed weekly for 8 weeks, then 3 random meals services weekly for 8 weeks, then 2 random meal services weekly for 36 weeks. The results of the audit will be reviewed monthly at the quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits. **V. Plan of Correction completion date: 3/19/23**	
F 9999 Bldg. 00	3.1-4 NOTICE OF RIGHTS AND SERVICES (f) The facility must do the following: (11) If the facility is required to submit an Alzheimer's and dementia special care unit disclosure form under IC 12-10-5.5, provide the resident at the time of admission to the facility with a copy of the completed Alzheimer's and dementia special care unit disclosure form. This state rule was not met as evidenced by: Based on interview and record review, the facility	F 9999	**I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** The Alzheimer's and dementia special care unit disclosure form was submitted for the current year.**II. The facility will identify other residents that may potentially be affected by the practice**Residents residing on the dementia unit have the potential to be affected by the practice. **III.**	03/19/2023

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	failed to ensure the State form Alzheimer's / Dementia Special Care Unit was completed and submitted every year and by the December 31st deadline for 2 of 3 years reviewed. Findings include: On 2/13/23 at 10:20 a.m., the Administrator provided the facility's most recent Alzheimer's / Dementia Special Care Unit state form. It was dated 1/5/23. The previous one submitted was dated 3/11/19. During an interview, on 2/14/23 at 10:21 a.m., the Administrator indicated the facility completed the 2019 Alzheimer's / Dementia Special Care Unit form on paper and did not realize the form was online for 2020 and 2021. He indicated he realized the current form, dated 1/5/23, was submitted late.		**The facility will put into place the following systematic changes to ensure that the practice does not recur.**The administrative team has been re-educated on the requirements of submitting the Alzheimer's and dementia special care unit disclosure form yearly and by the December 31st deadline. **IV. The facility will monitor the corrective action by implementing the following measures.** The regional director of operations will review Alzheimer's and dementia special care unit disclosure form annually in the month of December to ensure its timely submission. The results of these reviews will be discussed at the monthly facility Quality Assessment and Performance Improvement meeting monthly for 6 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed if compliance is below 100%.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Nursing Home Complaints IN00399873 and IN00395302.	R 0000		

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	Complaint IN00399873 - Unsubstantiated due to lack of evidence. Complaint IN00395302 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Survey dates: February 7, 8, 9, 10, 13, 14, 15, and 16, 2023. Facility number: 013455 Residential Census: 59 Cumberland Trace Health & Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review completed on March 2, 2023.			