STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155807	A. BUILDING 00 B. WING	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RURAL HEALTH CARE CENTER	1747 N RURAL ST INDIANAPOLIS, IN 46218

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00422769. Complaint IN00422769 - Federal/state deficiencies related to the allegations are cited at F0677 and F0584. Survey dates: December 7, 8, 11, 12, 13, and 14, 2023. Facility number: 000388 Provider number: 155807 AIM number: `00454140 Census Bed Type: SNF/NF: 33 Total: 33 Census Payor Type: Medicaid: 32 Other: 1 Total: 33 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 21, 2023	F 0000		
F 0565 SS=F Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space;			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matthew D. Shafer	HFA	01/08/2024

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	and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.			
	Based on observation, interview, and record review, the facility failed to act promptly upon resident council grievances regarding weekly shopping and maintenance work orders. This had the potential to affect 33 of 33 residents in the facility.	F 0565	The Resident has a right to organize and participate in resident groups in the facility. Activities Director educated on reviewing resident council grievances with responsible	01/11/2024

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	Findings include: The 9/29/23, 10/30/23, and 11/30/23 Resident Council Minutes and corresponding Resident council Follow Ups were provided by the AD (Activity Director) on 12/8/23 at 2:23 p.m. The 9/29/23 minutes indicated a social services grievance was that the SSD (Social Services Director) didn't go shopping on Wednesdays like before. The 9/29/23 corresponding Resident Council Follow Up to this grievance indicated the response was, "Social Services does go to the store." The follow up did not indicate when or how often social services would be going to the store. The 10/30/23 minutes indicated a social services grievance was that the SSD hadn't been shopping for them. The 10/30/23 corresponding Resident Council Follow Up to this grievance indicate the response was, "Shopping will start back up." The follow up did not indicate who would start shopping again, when, or how often. The 10/30/23 minutes indicated a maintenance grievance was that there was no follow up with resident work orders. The 10/30/23 corresponding Resident Council Follow Up to this grievance indicated the response was, "Will make a place for residents work orders only." The follow up did not indicate where this location would be or that residents were informed of the location. The 11/30/23 minutes indicated a maintenance grievance was to please follow up with work orders. The 11/30/23 corresponding Resident Council Follow Up to this grievance indicated the response was, "Will meet with maintenance		department head and giving a copy of grievances to Administrator. Administrator will ensure grievances addressed timely and properly, AD will follow up on grievances at next resident council to ensure all have been resolved. Activity Director will do resident shopping weekly. Maintenance Director working to repair/replace items listed in resident council All residents have potential to be affected by alleged deficiency Activity Director will do resident shopping weekly. Maintenance Director working to repair/replace items listed in resident council Activities Director educated on reviewing resident council grievances with responsible department head and giving a copy of grievances to Administrator. Administrator will ensure grievances addressed timely and properly, AD will follow up on grievances at next resident council to ensure all have been resolved. Activities Director will review resident council grievances with responsible department head and give a copy of grievances to Administrator. Administrator will ensure grievances addressed timely and properly, AD will follow up on grievances at next resident council to ensure all have been	

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	weekly to go over his to do list." The follow up did not indicate who would meet with maintenance weekly to go over his to do list. A resident council meeting was held on 12/8/23 at 10:30 a.m. Twenty residents were in attendance. The council indicated social services not going shopping was still a problem, and maintenance not following up on work orders was still a problem. An interview was conducted with the SSD on 12/11/23 at 11:16 a.m. She indicated she was the grievance official and was aware that shopping for residents was a concern. She used to do weekly shopping on Wednesdays for residents, but she was no longer doing that. The activities department was now responsible for the weekly shopping and had been since around late August, 2023. When the ED began working at the facility in August, 2023, he made the activity department responsible for shopping. She still went shopping for residents "here and there," but not weekly like she used to do. She didn't know anything about maintenance work order grievances, as the maintenance department would be responsible for that. She hadn't seen the maintenance supervisor "in about a week. He's not here much." AA (Activity Assistant) 11 joined in at the end of this interview. AA 11 indicated no one had said anything to her about the activities department being responsible for shopping, so activities hadn't been doing any shopping for residents to her knowledge. A telephone interview was conducted with the AD on 12/11/23 at 11:41 a.m. in the presence of AA 11. The AD indicated she was never updated that activities was supposed to be responsible for shopping for residents. She wrote down the		resolved. Administrator will monitor all grievances daily x 1 month; 3 times a week for 1 month and then weekly x 4 months and as needed The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	resident council grievances at meetings and completed the Resident Council Follow Up forms, so she'd been writing down the shopping concerns and took them to the SSD. Both the ED and SSD signed off on the forms. Even as of right now, no one ever informed her activities was responsible for shopping. An interview was conducted with the SSD on 12/11/23 at 12:05 p.m. She indicated she wrote the response of shopping will start back up on the 10/30/23 Resident Council Follow Up form, because that was when it was discussed that activities would be responsible. An interview and observation of the nurse's desk was conducted with the ED on 12/11/23 at 12:14 p.m. He indicated activities typically did the shopping. There were 3 employees in the activity department, so they had plenty of staff to do it, and he'd discussed this with the AD. As far as the 10/30/23 Resident Council Follow Up form indicating a place for work orders, that meant a location for residents to grab a work order or for staff to complete it. The location was at the nurses desk. As far as the 11/30/23 Resident Council Follow Up form indicating meeting with maintenance weekly, he thought perhaps the AD wanted to meet with maintenance weekly. He signed off on the follow up form, because he was attempting to just meet with maintenance, but there were currently issues with maintenance showing up to work. There was a folder behind the nurse's desk containing blank work orders. The SSD provided the Filing Grievance/Complaints policy on 12/13/23 at 11:36 a.m. It read, "All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care			

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	in the facility will be considered. Actions on such issues will be responded to in writing including a rationale for the response." 3.1-3(l)			
F 0567 SS=D Bldg. 00	483.10(f)(10(i)(ii) Protection/Management of Personal Funds §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that			

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	is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. Based on observation, interview and record review, the facility failed to ensure the availability of a resident's funds on the weekend for 1 of 1 residents reviewed for access of personal funds. (Resident K) Findings include: The clinical record for Resident K was reviewed on 12/11/23 at 11:00 a.m. The resident's diagnosis included, but was not limited to, bipolar. The 8/9/23 Quarterly MDS (Minimum Data Set) assessment indicated Resident K was cognitively intact. A random observation was made of the Business Office Manager (BOM) on 12/11/23 at 8:25 a.m. BOM was observed with a nursing staff person at a medication cart retrieving money from the cart. BOM then went back to the office with the money. A random observation was made of Resident K during a medication administration with Qualified Medication Aide (QMA) 8 on 12/11/23 at 8:20 a.m. Resident K was observed to be upset and yelling down the hallway. Resident K had indicated to QMA 8 she could not get any money over the weekend. QMA 8 indicated to Resident K she heard her ask for the money over the weekend, and was declined. She stated, " I do not touch the	F 0567	The facility ensures that residents have the right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. BOM followed up with Resident K to ensure she was good and satisfied with funds currently. All residents have the potential to be affected by this finding. All staff in-serviced on resident funds on Evenings and Weekends as well as the lock box with resident funds in Medication cart. BOM in-serviced by RDO on importance of resident funds. Reminders posted at Nurses Station and on Lock Box to call BOM and/or Admin. if insufficient funds to meet resident's needs. All staff in-serviced on resident funds on Evenings and Weekends as well as the lock box with resident funds in Medication cart. BOM in-serviced by RDO on importance of resident funds. Reminders posted at Nurses Station and on Lock Box to call BOM and/or Admin. if insufficient	01/11/2024

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	residents' money, only the nurses." An interview was conducted with the Business Office Manager (BOM) on 12/13/23 at 10:50 a.m. She indicated Resident K does have money in her account. She should have been able to get some money over the weekend as she requested. BOM stores money in the medication carts for the nursing staff to provide if a resident requests for money over the weekend. BOM was not sure why the agency staff that worked over weekend didn't give Resident K money as she requested. It does happen when agency staff work. A banking hours notification sign posted outside of the BOM office was provided by the Social Services Director on 12/13/23 at 11:36 a.m. It indicated banking hours was Monday through Friday from 8:00 a.m. to 4:00 p.m. After those hours, resident funds are available at the nurse's station. A "Resident Facility Trust Fund Policy and Procedure" was provided by the Social Services Director on 12/13/23 at 11:36 a.m. It indicated "...Residents of a skilled facility should be allowed to have personal spending money available to them. They have the right to have the money safeguarded and accounted for by the facility, and the right have any funds on deposit with the facility, over Fifty Dollars ($50.00) earn interest...Normal Process of Handling Resident Trust. 1. Resident Banking hours are posted at the business office...3. The resident is able to request and receive funds from this account at any time with the condition the resident sign the disbursement receipt as proof the resident received funds..." 3.1-6(f)(1)		funds to meet resident's needs. BOM and/or Designee will audit on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months to ensure residents are satisfied with how they are receiving their funds, as well as receiving them on Evenings and Weekends. Any concerns will be addressed as discovered. If any patterns are identified, an action plan will be written at the monthly QAPI meeting by the QAPI committee. Any written action plan will be monitored by the Admin and/or Designee monthly until resolved and substantial compliance is achieved.	

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F 0584 SS=E 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 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			

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	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 provide a comfortable, homelike environment for 6 of 33 residents in the facility. (Residents D, E, F, G, H, and J) Findings include: An observation of Resident E's and J's room was made on 12/7/23 at 12:36 p.m. There was a hole on the right side of the window. An interview was conducted with Resident at this time. She indicated cold air came into the room from the hole at night. An observation of Resident E and J's room was made on 12/7/23 at 3:04 p.m. There was a hole on the right side of the window. An interview was conducted with Resident 16 at this time. She indicated a the hole in the window was from a bullet and it let cool air into the room. There were missing baseboards on each side of the bathroom wall. A tour of the facility was conducted with the ED (Executive Director) and MS (Maintenance Supervisor) on 12/12/23 at 2:30 p.m. The hole in Resident E's and J's window was observed during the tour. Resident 16 was present for this observation and indicated the hole had been there for a year, ever since she lived in the facility, and it in let cold air. The ED indicated he thought a rock hit the window during lawn mowing and they could seal around the hole. The ED put his hand up the hole and indicated he could feel cold air. The missing baseboards remained on each side of the bathroom wall.	F 0584	The facility will provide a home like environment. Window in resident E & J's room was replaced, missing baseboards on each side of bathroom wall were replaced. Resident F's heating/cooling unit with missing knobs was repaired. Resident G's wall by door was repaired. Resident D's outlet was replaced. Resident H's missing drywall and baseboard by bathroom was replaced Baseboard trim throughout the hallway has been replaced All residents were at risk of this alleged deficient practice. Facility rounds were made to identify any other potential affected items and correct. Maintenance Director in-serviced on the Facility's Policy & Procedure. In-service included discussion on homelike environment for all residents and their responsibility to keep items in good repair. Staff & residents educated on where work orders can be found and the process for filling them out. The Admin/DON/Designee will do unannounced walking rounds daily on working days x 1 month; 3 times a week for 1 month and then weekly x 4 months to observe for	01/11/2024

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	An observation of Resident F's room was made on 12/7/23 at 3:06 p.m. There were 2 knobs missing on the heating/cooling unit in his room. A tour of the facility was conducted with the ED (Executive Director) and MS (Maintenance Supervisor) on 12/12/23 at 2:30 p.m. An observation of Resident F's heating/cooling unit was made during the tour. The MS indicated he was unaware of the missing knobs and hadn't received any work orders about the missing knobs. The ED indicated they needed to order more knobs. An observation of Resident G's room was made on 12/7/23 at 10:53 a.m. The wall by the door was slanted outward with paint coming off the wall. Resident G indicated the wall needed fixed. A tour of the facility was conducted with the ED (Executive Director) and MS (Maintenance Supervisor) on 12/12/23 at 2:30 p.m. An observation of the slanted wall in Resident G's room was made during the tour. The MS indicated he was unaware of the slanted wall and chipping paint and hadn't received any work orders about it. An observation of Resident D's bathroom was made on 12/7/23 at 2:39 p.m. The outlet cover was cracked and broken. Resident D indicated maintenance in the facility was "really bad." A tour of the facility was conducted with the ED (Executive Director) and MS (Maintenance Supervisor) on 12/12/23 at 2:30 p.m. An observation of the cracked outlet cover in Resident D's bathroom was made. The MS indicated he was unaware of the cracked outlet		an appropriate homelike environment. Corrections will be made immediately with further staff education as needed. The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	cover and hadn't received any work orders about it. An observation of Resident H's room was made on 12/7/23 at 4:11 p.m. There was a missing section of drywall and baseboard by the bathroom. Resident H indicated it had been that way for a while. A tour of the facility was conducted with the ED (Executive Director) and MS (Maintenance Supervisor) on 12/12/23 at 2:30 p.m. An observation of the missing drywall and baseboard was made during the tour. The MS indicated he was unaware of the missing drywall and baseboard and hadn't received any work orders about it. During the tour of the facility with the ED and MS on 12/12/23 at 2:30 p.m., the baseboard trim throughout the hallways of the facility was pulling from the walls. The ED indicated he'd purchased 2 rolls, which was 400 feet of baseboard trim, but needed a total of 1800 feet, approximately 5 more rolls. The Maintenance Service policy was provided by the ED on 12/13/23 at 3:48 p.m. It read, "1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: ...b. Maintaining the building in good repair and free from hazards." This citation relates to Complaints IN00422769. 3.1-19(f)(5)			

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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
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable			

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	155807	A. BUILDING 00 B. WING	12/14/2023

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	expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the			

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	pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.			
	Based on interview and record review, the facility failed to timely address and provide follow up to a resident's grievance for 1 of 1 resident's grievance reviewed. (Resident 33) Findings include: The clinical record for Resident 33 was reviewed on 12/8/23 at 9:00 a.m. The resident's diagnosis included, but was not limited to, paraplegia (paralyzed of the lower body) The 9/5/23 Admissions MDS (Minimum Data Set) assessment indicated Resident 33 was cognitively intact. An interview was conducted with Resident 33 on 12/8/23 at 9:06 a.m. He indicated he does not like his roommate, and he wants to change rooms. The resident's roommate was disrespectful. He had	F 0585	The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Resident 33 interviewed by SSD. Resident 33 room move was completed per resident request on 12/11/23. All residents have potential to be affected by alleged deficient practices. SSD will review all grievances with the responsible department head and give a copy of grievances to Administrator. Administrator will ensure grievances addressed timely and properly. SSD will review all grievances	01/11/2024

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	requested to change rooms a few weeks ago, but it still has not happened. The facility staff had not given him any follow up or reason why he can not move. A grievance form dated 11/22/23 for Resident 33 was provided by the Social Services Director (SSD) on 12/11/23 at 11:30 a.m. It indicated the resident had requested to change rooms. The staff had to wait until room repairs was completed. The follow up on the grievance undated indicated, "We will accommodate the move today." The resolution section of the form was left blank, and the Executive Director signed the form. An interview was conducted with SSD on 12/11/23 at 12:07 p.m. She indicated she was the facility's Grievance Official. Resident 33 had requested to change rooms a few weeks ago. Resident 33 approximately a week ago had been introduced to his new roommate, and they get along great. "I think they will be a good fit!" Resident 33 had inquired again about moving on 12/8/23, so she had spoken to the the Executive Director about it. "I can only do so much." After speaking with the ED he had indicated due to room repairs that was needed; the resident was unable to be moved. A resident was currently occupying the room, so she was unsure what repairs were needed that would delay Resident 33's move. An interview was conducted with the Director of Nursing on 12/13/23 at 2:30 p.m. She indicated Resident 33 had been moved. A Grievance policy was provided by the SSD on 12/13/23 at 11:36 p.m. It indicated "...Residents and their representatives have the right to file grievances, either orally or in writing, to the		daily on working days and give a copy to Administrator. Administrator will follow up on grievances to ensure they have been addressed. Administrator or Designee will audit grievances daily on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	facility staff or to the agency designated to hear grievances...8. Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such finds to the Administrator within five (5) working days of receiving the grievance and/or complaint...12. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems. a. The Administrator, or his or her designee, will make such reports orally within ___ working days of the filing of the grievances or complaint with the facility..." 3.1-7(a)(2)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to protect the residents' right to be free from physical abuse by another resident for 3 of 6	F 0600	Freedom from Abuse, Neglect, and exploitation Resident 13 remained on one-on-one supervision until she	01/11/2024

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	Residents reviewed for abuse (Resident 13, 18, and 31). Findings include: 1 a. The clinical record for Resident 13 was reviewed on 12/7/23 at 3:19 p.m. The Resident's diagnosis included, but were not limited to, schizoaffective disorder and anxiety disorder. A care plan, initiated 2/23/23, indicated Resident 13 had episodes of physical aggression. The goal was for her not to harm herself or others. The interventions included to administer medications as ordered, initiated 2/23/23, analyze times of day, places, circumstances, triggers and what de-escalated behavior and document, initiated 2/23/23, give as many choices as possible about care and activities, initiated 9/27/23. A Quarterly MDS (Minimum Data Set) Assessment, completed 9/25/23, indicated she was cognitively intact and able to move around the facility independently. A care plan, initiated 9/27/23, indicated Resident 13 was easily angered. The goal was for her to remain free from injury and harm. The interventions included to be sensitive and cautious when approaching resident for care, initiated 9/27/23, develop a daily routine with consistency and structure keeping stress and demands low. Praise her for appropriate behavior, initiated 9/27/23, staff who work best with resident to care for her and work in pairs as able, initiated 9/27/23, and use direct communication and be concrete when speaking to her, initiated 9/27/23. 1 b. The clinical record for Resident 18 was		hospitalized with hyponatremia and passed away. Resident 18 was monitored by SSD for psychosocial distress All residents have potential to be affected by alleged deficiency Staff educated on Abuse policy and procedures, Behavior management & prevention, as well as behavior tracking. SSD continues to meet with residents to discuss psychosocial needs. All facility staff educated on the Facility abuse policy with a focus on residents behaviors/reporting. The DON or designee will review nurses/behavior notes and SSD will review behavior book daily on working days to ensure no allegations were documented and not reported and all behaviors addressed. All documentation Identified as potential abuse will be reported to ISDH by the Administrator or assigned designee and the Administrator will ensure an investigation is initiated immediately upon notification and fully completed on each incident. Residents, families and/or POAs will be notified after each incident and educated as needed.\ The DON or designee will review nurses/behavior notes and SSD will review behavior book daily on working days to ensure no allegations were documented and not reported and all behaviors	

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	reviewed on 12/8/23 at 11:27 a.m. The Resident's diagnosis included, but were not limited to, traumatic brain injury and anxiety disorder. An Annual MDS Assessment, completed 10/30/23, indicated she was cognitively intact and needed maximum assistance of staff for moving around the facility. Resident 13's clinical record contained a Behavior Note, dated 9/27/23 at 10:10 a.m., indicated that Resident 13 had become aggressive and ran down the hallway making contact with another resident in the back of the head. Redirection attempted unsuccessfully. The Psychiatric Nurse Practitioner was in the facility and gave a one-time order for Haldol 5 mg (milligram) IM (Intermuscular injection) Stat (right away). On 12/8/23 at 11:27 a.m., the ED (Executive Director) provided the reportable incident investigation file for the incident between Resident 13 and Resident 18. The investigation file included the Incident report, which was submitted to the Indiana Department of Health, on 9/27/23. The incident report indicated Resident 13 came out of her room agitated, yelling, and cursing. Resident 13 made physical contact with Resident 18 to the back of her head. Resident 13's behavior was unprovoked by Resident 18. During an interview on 12/11/23 at 9:48 a.m., Resident 18 indicated she remembered the incident between herself and Resident 13. Resident 18 had in her wheelchair and rolled past Resident 13 when Resident 13 came up behind Resident 18 and hit her in the back of the head. Resident 18 indicates she felt safe but continued to feel anxious when Resident 13 was around.		addressed working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	2 a. The clinical record for Resident 13 was reviewed on 12/7/23 at 3:19 p.m. The Resident's diagnosis included, but were not limited to, schizoaffective disorder and anxiety disorder. 2b. The clinical record for Resident 31 was reviewed on 12/11/23 at 8:45 a.m. The Resident's diagnosis included, but were not limited to, major depressive disorder and diabetes. A Quarterly MDS Assessment, completed 11/9/23, indicated that Resident 31 was cognitively intact and needed set up assistance to move around the facility. Resident 13's clinical record contained a Health Status Note, dated 12/9/23 at 8:29 p.m., which indicated Resident 13 was receiving one on one supervision due to aggressive behavior. Resident 13 had been calm and cooperative with care and relaxed throughout the day. Another patient was wheeling down the hallway when Resident 13 hit them. During an interview on 12/11/23 at 9:25 a.m., the ED indicated that Resident 13 had hit Resident 31 on 12/9/23. During an interview on 12/11/23 at 9:39 a.m., Resident 31 indicated that Resident 13 was known for hitting people. Resident 31 had wheeled past Resident 13's room on the evening on 12/9/23 when Resident 13 came out of her room and pulled Resident 31's wheelchair backward. Resident 13 then hit Resident 18 in the eye. Resident 31's right eye had a small, scabbed area just under the eyebrow and a scabbed area on the right eyelid. Resident 31 indicated that his eye had become swollen and that the scabbed areas were from when Resident 13 had hit him. Resident 31 was			

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	apprehensive to be around Resident 13 because he did not want her to hit him again. On 12/8/23 at 10:00 a.m., the ED provided the Abuse and Neglect Policy, last revised 4/1/2017, which read "...Each resident has the right to be free from abuse, neglect, and misappropriation of resident property. All allegations will be reported according to State and Federal Law and investigated...Definitions.... 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish...'Physical abuse' includes hitting, slapping, pinching, and kicking...Prevention ...the clinical staff will assess, care plan, and monitor residents with needs and behaviors that might lead to conflict or neglect, such as residents with a history of aggressive behaviors...The facility will implement action to prevent further potential abuse while the investigation in in progress..." 3.1-27(a)(1)			
F 0602 SS=E Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on observation, interview, and record review, resident funds were misappropriated for 11 of 11 residents randomly reviewed for misappropriation. (Residents H, J, 8, 20, 18, 19, 23, 25, 28, 29, and 32)	F 0602	The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in the subpart.	01/11/2024

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	Findings include: An anonymous interview was conducted. They indicated the ED (Executive Director) cashed resident's checks for the facility from their resident funds accounts. He had a cigarette check to cash, but didn't come back with $700 of the money. The BOM (Business Office Manager) kept telling the ED she needed the missing money, but he kept "spinning us," and they never got the money. The activity department was short between $600 and $700 because of the missing money. The process for buying residents cigarettes out of money from their trusts was to create a list, because the list was large. The facility received a check to buy the cigarettes and then they'd go buy them. When the cigarettes were to be purchased a couple months ago, there wasn't enough money. The activities department was unable to purchase things for their department the past few months, because the ED owed the activities department money from the missing cigarette money. The ED cashed another check the BOM was waiting on and brought the money to the DON (Director of Nursing), but some of it was missing and the ED blamed the DON. The BOM's books show the missing money. This was all reported to the Regional Director. An interview was conducted with the BOM on 12/13/23 at 4:13 p.m. She indicated she was in charge of the resident fund accounts. The process for purchasing residents cigarettes from their resident fund account was for the AD (Activity Director) to go around each month and ask each resident what brand and how many cigarettes they wanted to purchase. Activities had a list of the pricing as well. An order form was completed by activities that included each resident with their order and each resident signed off on it. The AD		All funds in question for resident 20, H, J, 8, 20, 18, 19, 23, 25, 28, 29 & 32 have been reconciled/accounted for. All checks are now being made out to another department head for cashing. There is now a signature sheet in place for checks/cash given and received. All resident have potential to be affected by alleged deficiency ED, BOM, and staff educated on abuse, misappropriation, timely cashing of checks and fund reconciliation. All checks are now being made out to another department head for cashing. There is now a signature sheet in place for checks/cash given and received ED & BOM educated on new procedures for check cashing. Policies reviewed for resident funds. All checks are now being made out to another department head for cashing. There is now a signature sheet in place for checks/cash given and received BOM will monitor resident funds, checks, cash received and ensure new signature sheet being implemented daily on working days x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report	

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	then gave the completed order form to her and she submitted it to corporate accounts receivable, who would enter a withdrawal amount for each resident from their resident fund account. Accounts receivable generated a check usually made out to the ED. This month the check was made out to the MDSC (Minimum Data Set Coordinator) instead. Whoever cashes the check brings the cash in to her. She then gives the money and copy of the cigarette order to activities to go buy cigarettes. There was a month that the amount of money she gave the AD was not enough to cover the cigarette order. It was 9/1/23. The cash the BOM gave the AD was $690 short. The AD pulled the money to cover the cigarettes, almost $700, from her activities fund and country cart/commissary budget that she controls. The country cart/commissary budget was for resident snacks and personal items. The BOM knew the cash was short for the cigarette list when she handed the money over to the AD. When the ED gave the BOM the cash, he said it wasn't all there and that he would bring her the rest of the money the following day, as there was an issue with his bank and they would only allow him to withdraw so much. The cigarette check was made out to the ED in the amount of $1634 and some change. The ED gave the BOM only $940 cash, and the ED did not give her the rest of the money the following day as he said he would. "To this day, the ED has not given me the money." The $1634 came from corporate withdrawing it from resident fund accounts, because it was for their cigarettes. The ED hadn't brought her the right amount of cash for several petty cash transactions, including vehicle expenses. The BOM had several discussions with the ED about the missing cigarette money. The BOM also informed the Regional Director about the missing money. The Regional Director asked the BOM to come to the		the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	ED's office and ask him about the money in front of her. The BOM did this and the ED informed he would be going to the bank that day to get it, but that didn't happen. The Regional Director requested the BOM request the specific amount of money from the ED through a text message, so there was documentation. The BOM did this on 11/29/23. The ED responded via text message that he was going to bring the money. There was also a check for Resident 20 in the amount of $384.37 for clothing that was made out to the ED on 10/30/23, that the BOM was most concerned about. The BOM never received the cash from this check either. The ED informed the BOM via text that he may have left it on his desk. The ED to this day had never brought her the $384.37 cash for Resident 20's clothing, so thus far, Resident 20 still hadn't gotten new clothing from this money. "[Name of Resident 20] never got her clothing because we never got the money." Resident 20's niece was upset about the lack or condition of clothing in her closet. The BOM discussed it with her and said they would go out and buy her new clothing. Resident 20 had recently started going for regular chemotherapy appointments and needed new clothing for the appointment. The SSD (Social Services Director) and BOM got together and decided to look into Resident 20's resident fund account to see if she had money for new clothing, which she did, and that's how the $384.37 check ended up being disbursed. Resident 20's clothing check and the cigarette check were the only missing money that came from resident funds. On 12/13/23 at 4:55 p.m., the BOM provided a copy of the 10/30/23 Resident Trust Check Request for Resident 20 in the amount of $384.37 with a check payable to the ED.			

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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 12/13/23 at 4:55 p.m., the BOM provided a copy of the Withdrawal Transaction Report from Resident 20's fund account. It indicated $384.37 was withdrawn on 11/1/23 for personal needs items. On 12/13/23 at 4:55 p.m., the BOM provided a copy of the 8/21/23 Resident Trust Check Request for cigarettes in the amount of $1634.00 with a check payable to the ED. On 12/13/23 at 4:55 p.m., the BOM provided a copy of the Cigarette Order Form with Residents H, J, 8, 20, 18, 19, 23, 25, 28, 29, and 32's individual cigarette orders, signed by 10 of the 11 residents. On 12/13/23 at 4:55 p.m., the BOM provided a copy of the Withdrawal Transaction Report from Residents' H, J, 8, 20, 18, 19, 23, 25, 28, 29, and 32's fund accounts. It indicated a total of $1634. 35 was withdrawn from their 11 accounts on 8/22/23 for tobacco. An interview was conducted with the ED and Regional Director on 12/13/23 at 5:26 p.m. The ED indicated when he received a check, he would cash it and bring the money back to the BOM. He was short $100 two weeks ago, but he assumed the bank shorted him, because he didn't count it. The ED indicated he brought the entire $1634 cash from the cigarette check back to the BOM. The ED had to use his own bank and if he cashed a check that was for more than what's in his account, the check had to sit in the bank for a day to clear, and that had happened to him before. The ED indicated he was certain he could prove the $694 missing from the cigarette check was given to the BOM the following day. The ED and the BOM were supposed to sign something every time they exchanged money, but he was not sure they did			

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	155807	A. BUILDING 00 B. WING	12/14/2023

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	that every time. As far as Resident 20's $384.37 check for clothing, the ED would need to look further into that. The Regional Director indicated the BOM informed her there was a check the ED was only able to withdraw a certain amount for a couple of weeks ago and about the missing $100 from a couple weeks ago. An interview and observation was conducted with the BOM on 12/14/23 at 9:35 a.m. A stack of cash was on her desk to the right of her computer. She indicated all the missing cash was given to her by the ED this morning, including the $694 from the cigarette check and the $384.37 for Resident 20's clothing. She indicated they don't sign anything when cash is given to her. She documented withdraws from each fund on sticky notes and kept the notes in each of the different blue bank bags for each separate fund. The BOM hadn't reconciled the activities or commissary accounts since August, 2023, because there hadn't been any money in the accounts since it was taken to pay for cigarettes. On 12/14/23 at 9:49 a.m., the BOM provided a copy of a sticky note from the activity bank bag. It read, "$334 cigarettes Activities 9/1/23." On 12/14/23 at 9:49 a.m., the BOM provided a copy of a sticky note from the commissary bank bag. It read, "$300 cigarettes commissary." On 12/14/23 at 9:49 a.m., the BOM provided the 9/1/23 cigarette receipt from the store where the cigarettes were purchased. The receipt totaled $1634. 47. On 12/14/23 at 9:49 a.m., the BOM provided text messages between her and the ED dated 11/29/23 regarding the missing moneys.			

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	On 12/14/23 at 10:35 a.m., the BOM provided emails between her and the Regional Director dated 11/29/23 regarding the missing moneys. An interview was conducted with the ED on 12/14/23 at 11:15 a.m. He indicated the money he gave the BOM this morning accounted for all the money missing from resident funds for which he was accountable. The Abuse policy was provided by the ED on 12/8 at 10:00 a.m. It read, "Each resident has the right to be free from abuse, neglect, and misappropriation of resident property. All allegations will be reported according to State and Federal Law and investigated...Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent." 3.1-28(a)			
F 0607 SS=C Bldg. 00	483.12(b)(1)-(5)(ii)(iii) Develop/Implement Abuse/Neglect Policies §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,			

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	§483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. Based on observation, interview, and record review, the facility failed to post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if they believe the facility has retaliated against an employee or individual who reported a suspected crime and how to file such a complaint. This had the potential to affect 33 of 33 residents in the facility. Findings include: A tour of the facility was conducted with the ED (Executive Director) on 12/14/23 at 10:40 a.m. in an attempt to locate a posting of a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if they believe the facility has retaliated against an employee or individual who reported a suspected crime and how to file such a complaint. No such posting was located.	F 0607	Develop/Implement Abuse/Neglect Policies Notice of employee rights, including the right to file a complaint with the State survey Agency was posted in a conspicuous place. All residents have potential to be affected by alleged deficient practice. Poster now hanging in hallway in direct view of all staff ED/BOM educated by RDO on ensuring Poster in place. Staff educated on Employee Rights. ED/BOM to monitor poster placement and ensure that it remains in place and visible to staff Admin or Designee will audit placement on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4	01/11/2024

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	An interview was conducted with the ED during the above tour on 12/14/23 at 10:40 a.m. He indicated he knew what the notice was about, but didn't see it posted anywhere. The ED provided the Reporting Suspected Crimes Under the Elder Justice Act policy on 12/14/23 at 10:50 a.m. It read, Post a notice in a conspicuous location that informs all "covered individuals of: ...b. Their right to file a complaint with the state survey agency if they feel the facility has retaliated against an employee who reported a suspected crime under this statue." 3.1-28(a)		months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	
F 0609 SS=E Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.			

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	§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to timely report misappropriation of resident funds and to timely report an allegation of resident to resident physical abuse for 11 of 11 residents randomly reviewed for misappropriation and 1 of 6 residents reviewed for abuse. (Residents H, J, 8, 13, 20, 18, 19, 23, 25, 28, 29, and 32) Findings include: 1. An anonymous interview was conducted. They indicated the ED (Executive Director) cashed resident's checks for the facility from their resident funds accounts. He had a cigarette check to cash, but didn't come back with $700 of the money. The BOM (Business Office Manager) kept telling the ED she needed the missing money, but he kept "spinning us," and they never got the money. The activity department was short between $600 and $700 because of the missing money. The process for buying residents cigarettes out of money from their trusts was to create a list, because the list was large. The facility received a check to buy the cigarettes and then they'd go buy them. When the cigarettes were to be purchased a couple months ago, there wasn't enough money. The activities department was unable to purchase things for their department the past few months, because the ED owed the activities department money from the	F 0609	Reporting Alleged Violations All funds in question for resident 20, H, J, 8, 20, 18, 19, 23, 25, 28, 29 & 32 have been reconciled/accounted for. Resident 13 remained on one on one supervision until hospitalized with hyponatremia and passing away. ED, BOM, and staff educated on abuse, misappropriation, timely cashing of checks and fund reconciliation. ED & BOM educated by RDO on new procedures for check cashing. Policies reviewed for resident funds. Staff educated on Abuse policy and procedures, Behavior management & prevention, behavior tracking & Reporting all abuse and allegations of abuse. BOM will audit check cashing/cash on hand on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months DON will audit behavior management and prevention on working days daily x 1 month; 3 times week for 1 month and then	01/11/2024

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	missing cigarette money. The ED cashed another check the BOM was waiting on and brought the money to the DON (Director of Nursing), but some of it was missing and the ED blamed the DON. The BOM's books show the missing money. This was all reported to the Regional Director. An interview was conducted with the BOM on 12/13/23 at 4:13 p.m. She indicated she was in charge of the resident fund accounts. The process for purchasing residents cigarettes from their resident fund account was for the AD (Activity Director) to go around each month and ask each resident what brand and how many cigarettes they wanted to purchase. Activities had a list of the pricing as well. An order form was completed by activities that included each resident with their order and each resident signed off on it. The AD then gave the completed order form to her and she submitted it to corporate accounts receivable, who would enter a withdrawal amount for each resident from their resident fund account. Accounts receivable generated a check usually made out to the ED. This month the check was made out to the MDSC (Minimum Data Set Coordinator) instead. Whoever cashes the check brings the cash in to her. She then gives the money and copy of the cigarette order to activities to go buy cigarettes. There was a month that the amount of money she gave the AD was not enough to cover the cigarette order. It was 9/1/23. The cash the BOM gave the AD was $690 short. The AD pulled the money to cover the cigarettes, almost $700, from her activities fund and country cart/commissary budget that she controls. The country cart/commissary budget was for resident snacks and personal items. The BOM knew the cash was short for the cigarette list when she handed the money over to the AD. When the ED gave the BOM the cash, he said it wasn't all there		weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	and that he would bring her the rest of the money the following day, as there was an issue with his bank and they would only allow him to withdraw so much. The cigarette check was made out to the ED in the amount of $1634 and some change. The ED gave the BOM only $940 cash, and the ED did not give her the rest of the money the following day as he said he would. "To this day, the ED has not given me the money." The $1634 came from corporate withdrawing it from resident fund accounts, because it was for their cigarettes. The ED hadn't brought her the right amount of cash for several petty cash transactions, including vehicle expenses. The BOM had several discussions with the ED about the missing cigarette money. The BOM also informed the Regional Director about the missing money. The Regional Director asked the BOM to come to the ED's office and ask him about the money in front of her. The BOM did this and the ED informed he would be going to the bank that day to get it, but that didn't happen. The Regional Director requested the BOM request the specific amount of money from the ED through a text message, so there was documentation. The BOM did this on 11/29/23. The ED responded via text message that he was going to bring the money. There was also a check for Resident 20 in the amount of $384.37 for clothing that was made out to the ED on 10/30/23, that the BOM was most concerned about. The BOM never received the cash from this check either. The ED informed the BOM via text that he may have left it on his desk. The ED to this day had never brought her the $384.37 cash for Resident 20's clothing, so thus far, Resident 20 still hadn't gotten new clothing from this money. "[Name of Resident 20] never got her clothing because we never got the money." Resident 20's niece was upset about the lack or condition of clothing in her closet. The BOM discussed it with			

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	her and said they would go out and buy her new clothing. Resident 20 had recently started going for regular chemotherapy appointments and needed new clothing for the appointment. The SSD (Social Services Director) and BOM got together and decided to look into Resident 20's resident fund account to see if she had money for new clothing, which she did, and that's how the $384.37 check ended up being disbursed. Resident 20's clothing check and the cigarette check were the only missing money that came from resident funds. On 12/13/23 at 4:55 p.m., the BOM provided a copy of the 10/30/23 Resident Trust Check Request for Resident 20 in the amount of $384.37 with a check payable to the ED. On 12/13/23 at 4:55 p.m., the BOM provided a copy of the Withdrawal Transaction Report from Resident 20's fund account. It indicated $384.37 was withdrawn on 11/1/23 for personal needs items. On 12/13/23 at 4:55 p.m., the BOM provided a copy of the 8/21/23 Resident Trust Check Request for cigarettes in the amount of $1634.00 with a check payable to the ED. On 12/13/23 at 4:55 p.m., the BOM provided a copy of the Cigarette Order Form with Residents H, J, 8, 20, 18, 19, 23, 25, 28, 29, and 32's individual cigarette orders, signed by 10 of the 11 residents. On 12/13/23 at 4:55 p.m., the BOM provided a copy of the Withdrawal Transaction Report from Residents' H, J, 8, 20, 18, 19, 23, 25, 28, 29, and 32's fund accounts. It indicated a total of $1634. 35 was withdrawn from their 11 accounts on 8/22/23 for tobacco.			

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	An interview was conducted with the ED and Regional Director on 12/13/23 at 5:26 p.m. The ED indicated when he received a check, he would cash it and bring the money back to the BOM. He was short $100 two weeks ago, but he assumed the bank shorted him, because he didn't count it. The ED indicated he brought the entire $1634 cash from the cigarette check back to the BOM. The ED had to use his own bank and if he cashed a check that was for more than what's in his account, the check had to sit in the bank for a day to clear, and that had happened to him before. The ED indicated he was certain he could prove the $694 missing from the cigarette check was given to the BOM the following day. The ED and the BOM were supposed to sign something every time they exchanged money, but he was not sure they did that every time. As far as Resident 20's $384.37 check for clothing, the ED would need to look further into that. The Regional Director indicated the BOM informed her there was a check the ED was only able to withdraw a certain amount for a couple of weeks ago and about the missing $100 from a couple weeks ago. An interview and observation was conducted with the BOM on 12/14/23 at 9:35 a.m. A stack of cash was on her desk to the right of her computer. She indicated all the missing cash was given to her by the ED this morning, including the $694 from the cigarette check and the $384.37 for Resident 20's clothing. She indicated they don't sign anything when cash is given to her. She documented withdraws from each fund on sticky notes and kept the notes in each of the different blue bank bags for each separate fund. The BOM hadn't reconciled the activities or commissary accounts since August, 2023, because there hadn't been any money in the accounts since it			

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	was taken to pay for cigarettes. On 12/14/23 at 9:49 a.m., the BOM provided a copy of a sticky note from the activity bank bag. It read, "$334 cigarettes Activities 9/1/23." On 12/14/23 at 9:49 a.m., the BOM provided a copy of a sticky note from the commissary bank bag. It read, "$300 cigarettes commissary." On 12/14/23 at 9:49 a.m., the BOM provided the 9/1/23 cigarette receipt from the store where the cigarettes were purchased. The receipt totaled $1634. 47. On 12/14/23 at 9:49 a.m., the BOM provided text messages between her and the ED dated 11/29/23 regarding the missing moneys. On 12/14/23 at 10:35 a.m., the BOM provided emails between her and the Regional Director dated 11/29/23 regarding the missing moneys. An interview was conducted with the ED on 12/14/23 at 11:15 a.m. He indicated the money he gave the BOM this morning accounted for all the money missing from resident funds for which he was accountable. An interview was conducted with the BOM on 12/14/23 at 10:15 a.m. She indicated she did not suspect that the missing money was stolen. The ED told her he couldn't pull the entire amount in one day, maybe because his bank wouldn't let him take it. She didn't know where the money was, the ED's bank, she guessed. She questioned if she should report it to anyone other than the Regional Director, but she followed the chain of command. As far as reporting to IDOH (Indiana Department of Health,) law enforcement, Adult Protective			

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	Services, or any other agencies, she thought about it, but then IDOH came into the facility for survey. If it wasn't handled after IDOH left, she would probably have reported to IDOH. With previous EDs in the facility, there was never more than a 2 day delay in getting cash from checks made out to them. 2. The clinical record for Resident 13 was reviewed on 12/7/23 at 3:19 p.m. The Resident's diagnosis included, but were not limited to, schizoaffective disorder and anxiety disorder. A care plan, initiated 2/23/23, indicated Resident 13 had episodes of physical aggression. The goal was for her not to harm herself or others. The interventions included to administer medications as ordered, initiated 2/23/23, analyze times of day, places, circumstances, triggers and what de-escalated behavior and document, initiated 2/23/23, give as many choices as possible about care and activities, initiated 9/27/23. A Quarterly MDS (Minimum Data Set) Assessment, completed 9/25/23, indicated she was cognitively intact and able to move around the facility independently. A care plan, initiated 9/27/23, indicated Resident 13 was easily angered. The goal was for her to remain free from injury and harm. The interventions included to be sensitive and cautious when approaching resident for care, initiated 9/27/23, develop a daily routine with consistency and structure keeping stress and demands low. Praise her for appropriate behavior, initiated 9/27/23, staff who work best with resident to care for her and work in pairs as able, initiated 9/27/23, and use direct communication and be concrete when speaking to her, initiated 9/27/23.			

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	Resident 13's clinical record contained a Behavior Note, dated 10/29/23 at 11:12 p.m., which read "...Resident [13] has been verbally and physically abusive towards peers and staff. Resident came out of her room several times threatening others about being by her room. It was reported by visiting nuns [sic] that resident attempted to hit another resident. Another resident reported that she hit them as well. Resident called one of the staff a fat [...]. Resident told another staff to get out and came up to the nurses station with her fist up. Resident has been getting in other staff and peers personal space and arguing with others. Writer spoke with Psych NP... and an[sic] prn order for Haldol 5mg/ml[milliliter] IM prn [as needed] every 4 hours as needed for 48 hours. During an interview on 12/12/23 at 1:40 p.m., the DON indicated that she should have been informed of the incident on 10/29/23 and that the incident of resident-to-resident physical abuse should have been reported to the Indiana Department of Health. During an interview on 12/12/23 at 1:54 p.m., the ED indicated he should have been informed of the incident on 10/29/23 and that the incident should have been reported to the Indiana Department of Health and investigated. During an interview on 12/12/23 at 2:48 p.m., RN 3 indicated that she had been the nurse who was working and had made the behavior note on 10/29/23 at 11:12 p.m. about Resident 13. RN 3 had informed the DON of the incident and the ED had spoken with RN 3 the next day about Resident 13's behaviors. The Abuse policy was provided by the ED on 12/8 at 10:00 a.m. It read, "Each resident has the			

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	right to be free from abuse, neglect, and misappropriation of resident property. All allegations will be reported according to State and Federal Law and investigated...Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent....The facility will ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility. Alleged violations will be reported to the appropriate state agency and to other officials in accordance with Federal and State law." 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			

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	Based on interview and record review, the facility failed to thoroughly investigate an allegation of resident to resident physical abuse for 1 of 6 residents reviewed for abuse (Resident 13). Findings include: The clinical record for Resident 13 was reviewed on 12/7/23 at 3:19 p.m. The Resident's diagnosis included, but were not limited to, schizoaffective disorder and anxiety disorder. A care plan, initiated 2/23/23, indicated Resident 13 had episodes of physical aggression. The goal was for her not to harm herself or others. The interventions included to administer medications as ordered, initiated 2/23/23, analyze times of day, places, circumstances, triggers and what de-escalated behavior and document, initiated 2/23/23, give as many choices as possible about care and activities, initiated 9/27/23. Resident 13's clinical record contained a Behavior Note, dated 10/29/23 at 11:12 p.m., which read "...Resident [13] has been verbally and physically abusive towards peers and staff. Resident came out of her room several times threatening others about being by her room. It was reported by visiting nuns [sic] that resident attempted to hit another resident. Another resident reported that she hit them as well. Resident called one of the staff a fat [...]. Resident told another staff to get out and came up to the nurses station with her fist up. Resident has been getting in other staff and peers personal space and arguing with others. Writer spoke with Psych NP... and an[sic] prn order for Haldol 5mg/ml[milliliter] IM prn [as needed] every 4 hours as needed for 48 hours.	F 0610	Investigate/Prevent/Correct Alleged Violation All Staff educated on the Abuse/ incident investigation policy and procedure and reporting to the administrator in timely manner. The staff and Resident interviews were completed for incident involving Resident 13. All resident have potential to be affected by alleged deficiency. The DON completed an audit of Nurses/Behavior notes to ensure all items have been addressed, no new findings. The DON or designee will review nurses/behavior notes and SSD will review behavior book daily on working days to ensure no allegations were documented and not reported and all behaviors addressed. All Staff educated on the Abuse/ incident investigation policy and procedure and reporting to the administrator in timely manner The DON or designee will review nurses/behavior notes and SSD will review behavior book on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring. · by what date the systemic	01/11/2024

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	During an interview on 12/12/23 at 1:54 p.m., the ED indicated he should have been informed of the incident on 10/29/23 and that the incident should have been reported to the Indiana Department of Health and investigated. During an interview on 12/12/23 at 2:48 p.m., RN 3 indicated that she had been the nurse who was working and had made the behavior note on 10/29/23 at 11:12 p.m. about Resident 13. RN 3 had informed the DON of the incident and the ED had spoken with RN 3 the next day about Resident 13's behaviors. The Abuse policy was provided by the ED on 12/8 at 10:00 a.m. It read, "Each resident has the right to be free from abuse, neglect, and misappropriation of resident property. All allegations will be reported according to State and Federal Law and investigated..." 3.1-28(d)		changes for each deficiency will be completed.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and			

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	psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to ensure a resident had hypotension and hospice care plans, and to develop a care plan that included interventions to address a resident's refusal of medications for 1 of 5 residents reviewed for unnecessary medications and 1 of 1 resident reviewed for hospice. (Resident 15 and	F 0656	Develop/Implement Comprehensive Care Plan Midodrine order for resident 17 was clarified for nurses when to give and when to hold. Blood pressures are being documented for each ordered administration.	01/11/2024

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	17) Findings include: 1. The clinical record for Resident 17 was reviewed on 12/13/23 at 10:37 a.m. Her diagnoses included, but were not limited to, Alzheimer's disease, schizoaffective disorder, and hypotension. The physician's orders indicated to administer one 5 mg tablet of midodrine two times a day for hypotension and to hold if systolic blood pressure is greater than 130, effective 4/9/23. The December, 2023 MAR (medication administration record) indicated the midodrine was not given on the following dates and times due to outside of parameters: 12/5/23 in the morning, 12/7/23 in the morning, 12/8/23 in the morning and evening, 12/12/23 in the morning, and 12/13/23 in the evening. The December, 2023 MAR and blood pressures from vitals did not have documented blood pressures for the following administration times: 12/5/23 morning, 12/8/23 morning and evening, 12/12/23 morning, and 12/13/23 in the evening. The 12/7/23 morning administration blood pressure was 110/66, which was not outside of parameters for administration. An interview was conducted with the DON on 12/13/23 at 12:19 p.m. She reviewed Resident 17's December, 2023 documented blood pressures and indicated the 12/7/23 morning dose of midodrine should have been given and there should be documented blood pressures for each ordered administration. She thought nursing may have been confused by the greater than sign in the orders and may need it written out instead.		Care plan for hypotension and Hospice are now in place Resident 15 now has care plan indicating he will refuse medications at times. Medication times have been changed to fit resident preference. All residents have potential to be affected by alleged deficiency. MDS/SSD to review all resident diagnosis and behaviors to ensure appropriate care plans are in place. DON to monitor resident refusals and ensure follow up being completed and resident preferences being addressed. MDS/SSD to review all resident diagnosis and behaviors to ensure appropriate care plans are in place. DON to monitor resident refusals and ensure follow up being completed and resident preferences being addressed. MDS/SSD to review all resident diagnosis and behaviors to ensure appropriate care plans are in place. DON to monitor resident refusals and ensure follow up being completed and resident preferences being addressed. Administrator Designee will audit progress on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of	

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	There was no hypotension care plan included in Resident 17's care plans. An interview was conducted with the DON on 12/13/23 at 12:19 p.m. She indicated she did not see a hypotension care plan for her, but she should have one. The 12/7/2023, nurse's note read, "This patient's hospice nurse [name of hospice nurse] came into this facility to see this patient after this patient showed some signs of agitation. This writer took a verbal order per hospice to increase this patient's 1mg lorazepam to 4 times daily." There was no hospice care plan included in Resident 17's care plans. An interview was conducted with the MDSC (Minimum Data Set Coordinator) and SSD (Social Services Director) on 12/13/23 at 12:00 p.m. The MDSC indicated Resident 17 began receiving hospice services on hospice 12/8/22. The MDSC reviewed Resident 17's care plans and indicated she did not see a hospice care plan for her, but she should have one. The SSD indicated she was responsible for creating hospice care plans and that Resident 17 should "absolutely" have one. It needed to include interventions such as provision of activities of daily living, assessing coping strategies, her code status, and to work cooperatively with her hospice team. 2. The clinical record for Resident 15 was reviewed on 12/8/23 at 2:43 p.m. The resident's diagnosis included, but was not limited to, heart disease. (Resident 15) A care plan dated 12/6/21 indicated Resident 15 "...holds medications in mouth and doesn't		continued monitoring.	

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	swallow them. They are found later in bed..." The interventions put in place were the following: staff was to have resident sit up, open mouth after administration, ask if resident would like medications in applesauce, and praise if resident takes medications. A physician order dated 11/28/23 indicated the staff was to administer 7.5 milligrams of Olanzapine at bedtime for a diagnosis of Schizophrenia. A physician order dated 11/28/23 indicated the staff was to administer 150 milligrams of Zoloft daily for major depression. A physician order dated 11/28/23 indicated the staff was to administer 5 milligrams of Eliquis twice a day for heart failure. A physician order dated 11/28/23 indicated the resident was to receive 0.4 milligrams of flomax daily for urine retention. The December 2023 MAR indicated the following medications, days and times the resident had refused his medications: Flomax: 12/2/23, 12/3/23, 12/7/23, 12/9/23 and 12/10/23, Olanzapine: 12/2/23, 12/3/23, 12/4/23, 12/7/23, 12/9/23 and 12/10/23, and Zoloft: 12/3/23, 12/9/23 and 12/10/23 Eliquis: 12/2/23 - evening dose, 12/3/23 - morning and evening dosages, 12/4/23 - evening dose, 12/7/23 - evening dose, 12/9/23 - morning and evening dosages, and 12/10/23 - morning and evening dosages The resident did not have a care plan with			

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	interventions in place addressing the resident's refusal of medications. An interview was conducted with the Director of Nursing on 12/12/23 at 2:42 p.m. She indicated the resident did have a care plan in place for not swallowing medications but not refusing. The Care Plan Development and Review policy was provided by the DON on 12/13/23 at 1:17 p.m. It read, "Facility personnel will ensure development of a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs...All disciplines must initiate a care plan addressing pertinent issues related to the care of the resident...The comprehensive care plan is designed to: ...incorporate risk factors associated with identified problems and ways to manage said risk factors." 3.1-35(a) 3.1-35(b)(1) 3.1-35(a)(b)(2)			
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20,			

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	at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.			
	Based on interview and record review, the facility failed to prepare a discharge summary that included a recapitulation of the resident's stay, a final summary of the resident's status, a reconciliation of all pre and post discharge medications, and a discharge plan of care for 1 of 1 residents reviewed for discharge. (Resident 35) Findings include: The clinical record for Resident 35 was reviewed on 12/11/23 at 2:14 p.m. Her diagnoses included, but were not limited to: chronic obstructive pulmonary disease, type 2 diabetes, and schizophrenia. She was admitted to the facility on 10/13/23. The 10/15/23, nurse's note read, "Resident states that she is in chronic pain all the time. Resident also stated that she would be moving to Terre Haute. Resident moved rooms due to her	F 0661	Discharge Summary DON/Nursing staff educated on Policy/Procedure for discharges by RDO. Discharge Packet and guidelines reviewed. All resident have potential to be affected by alleged deficient practice. Discharge paperwork/packet now in binder at nurses station with instructions for all nursing staff DON/Nursing staff educated on Policy/Procedure for discharges by RDO. Discharge Packet and guidelines reviewed. Discharge paperwork/packet now in binder at nurses station with instructions for all nursing staff DON or Designee will audit discharges on working days daily x 1 month; 3 times a week for 1	01/11/2024

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	complaints of her roommate. Resident vitals were WNL [within normal limits.] Writer educated resident on breakthrough pain and the process of administering PRN [as needed] medications. Resident wanted pain meds [medications] given sooner than what they were able to be given. Will continue to monitor changes in condition." The 10/17/23 Discharge Summary note read, "Resident discharged to [name of facility.] Resident states she misses her family and just wants to return home. She also states everyone was very kind to her while she was here, she just wants to be closer to her sister. Resident denies pain or discomfort at this time. She is alert and oriented x [times] 4 able to make wants and needs known. Staff from [name of facility] assisted with loading her belongings into their bus. All medications sent with staff." There was no discharge summary that included a recapitulation of the resident's stay, a final summary of the resident's status, a reconciliation of all pre and post discharge medications, and a discharge plan of care. On 12/11/23 at 4:10 p.m., the DON provided a blank copy of their paper discharge summary and Discharge Instructions. They included a recapitulation of resident's stay, a final summary of status at the time of transfer/discharge, a post discharge plan of care, nursing needs, medications, treatments, dietary instructions, activities instructions, social services instructions, therapy instructions, and referral information. An interview was conducted with the DON (Director of Nursing) on 12/11/23 at 4:10 p.m. She indicated she was unable to locate a discharge		month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	summary for Resident 35. They were in the process of transitioning at the time of her discharge. The Discharge of Resident policy was provided by the DON on 12/11/23 at 4:10 p.m. It read, "PURPOSE: To provide a safe discharge from the facility and ensure continuity of care....PROCEDURE...When a discharge is anticipated, a resident must have a Discharge Summary that includes: A recapitulation of the resident's stay; A final summary of the resident's status to include components of the comprehensive assessment, at the time of the discharge, that is available for release to authorized persons and agencies with the consent of the resident or legal representative; A post-discharge plan of care that is developed with the participation of the resident and family/legal representative, which will assist the resident to adjust to his/her new/previous living environment. The post-discharge plan must be presented both orally and in writing and in a language that the resident and family understand; A post-discharge plan identifies specific resident needs after discharge such as personal are necessary dressings/treatments, and necessary therapy, and describes resident/caregiver education needs with provision of instruction where applicable, to prepare the resident for discharge." 3.1-36(a)(1) 3.1-36(a)(2) 3.1-36(a)(3) 3.1-36(a)(3)(b)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to			

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	carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to provide showers as scheduled, to provide complete bed baths, and to recognize and address a resident not wearing their dentures for 2 of 3 residents reviewed for Activities of Daily Living and 1 of 1 resident reviewed for dental status (Resident C, G, and K). Findings include: 1. The clinical record for Resident C was reviewed on 12/7/23 at 3:54 p.m. The Resident's diagnosis included, but were not limited to, diabetes with neuropathy (nerve pain) and renal failure. A care plan, last reviewed 11/7/23, indicated that Resident C needed assistance with ADL (Activities of Daily Living). The goal was for him to remain clean, dry, and well groomed. The approaches included that he was dependent on staff to provide him with a bath twice weekly and as necessary, initiated 11/21/21. A Quarterly MDS (Minimum Data Set) Assessment, completed 11/2/23, indicated Resident C was cognitively intact, needed maximum assist with bathing, was dependent with lower body dressing, dependent with putting on and taking off his footwear, and received dialysis. During an interview on 12/11/23 at 2:52 p.m., Resident C indicated that he had not had a shower in 2 months, he had received bed baths. Resident C would like to have a shower and have the water run over him so that he could feel clean. He was	F 0677	ADL care provided for Dependent Residents Resident C is being offered showers according to resident's preferred shower schedule. Staff have been educated on shower policies and procedures as well as bed bath policies and procedures. Resident G is being offered showers according to resident's preferred shower schedule. Staff have been educated on shower policies and procedures as well as bed bath policies and procedures. Resident K received denture glue of her choice. Nursing staff monitoring resident for use or refusals of wearing dentures. All resident have potential to be affected by alleged deficiency Shower audits and denture audits being completed by DON. Audits will be completed daily on working days x 1month, 3 times a week for 1 month and then weekly x 4months. Staff educated on shower, bed bath, & denture policy & procedures as well as resident preferences. Shower audits and denture audits being completed by DON. Audits will be completed daily on working days x 1month, 3 times a week for 1 month and then weekly x 4months.	01/11/2024

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	155807	A. BUILDING 00 B. WING	12/14/2023

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	supposed to have a shower twice weekly. On 12/12/23 at 11:32 a.m., the DON (Director of Nursing) provided the November and December 2023 shower sheets for Resident C, which indicated that he had received complete bed baths on 11/4/23, 11/5/23, 11/9/23, and 12/2/23. During an interview on 12/13/23 at 10:28 a.m., Resident C indicated that he was to receive showers on Wednesdays and Sundays. 2. The clinical record for Resident G was reviewed on 12/7/23 at 10:51 a.m. The Resident's diagnosis included, but were not limited to, hemiplegia (paralysis) of the right-side and diabetes. A care plan, last reviewed on 11/21/23, indicated that Resident G had an ADL self care performance deficit due to limited range of motion and hemiplegia. The goal was for him to be clean, dry, and neatly dressed daily. The approaches included that he needed assistance of 1 staff member to participate in bathing and to provide baths or showers per his preference, initiated 4/12/2019. A Quarterly MDS Assessment, completed 11/15/23, indicated he was cognitively intact, dependent on staff for full body bathing and dependent on staff for dressing and personal hygiene. On 12/7/23 at 10:51 a.m., Resident G was observed laying in his bed. The room has a smell of body odor. During an interview on 12/7/23 at 10:51 a.m., Resident G indicated that he had not received a		Staff educated on shower, bed bath, & denture policy & procedures as well as resident preferences. DON or Designee will audit on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	shower since last Tuesday. He was supposed to have them twice weekly. On 12/12/23 at 1:55 p.m., the DON provided the November and December 2023 shower sheets for Resident G with indicated he had received the following: 11/2/23- shower, 11/3/23- bed bath, 11/6/23-shower, 11/9/23- bed bath, 11/13/23- bed bath, 11/15/23- bed bath, 11/22/23- he had refused due to not feeling well, 11/27/23- shower, 11/30/23- he had refused, 12/4/23- he had refused, 12/7/23- bed bath, and 12/11/23- bed bath. During an interview on 12/12/23 at 1:59 p.m., Resident G indicate he had not been asked if he would like a shower since 12/7/23. When he received a bed bath the staff did not always use soap and water. The staff would wipe him down with the incontinence wipes. During an interview on 12/12/23 at 3:10 p.m., the DON indicated that wipes should not be used to provide a bed bath. 3. The clinical record for Resident K was reviewed on 12/7/23 at 2:50 p.m. Her diagnoses included, but were not limited to: Alzheimer's disease, schizoaffective disorder, chronic kidney disease, and vascular dementia. The 1/10/20 oral/dental health care plan indicated Resident K was edentulous. The goal was for her to maintain and retain a healthy oral and dental			

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	status. An intervention were to assist the resident with oral hygiene care as needed. The 1/10/20 activities of daily living care plan indicated she was highly involved in her own care but required supervision to extensive assistance with some tasks. Interventions were to provide necessary materials/equipment and to make sure the materials/equipment were clean and functioning appropriately and to assist with oral care as needed. The 12/5/23 Care Conference Note read, "...She does have dentures and wears this when she wants...." The 11/9/23 Annual MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status score) of 15, indicating she was cognitively intact. An observation and interview was conducted with Resident K on 12/7/23 at 2:54 p.m. She had no teeth or dentures in her mouth. She indicated she had false teeth, but didn't wear them, because she did not have the right glue for them. If she had the right glue, she would wear them. An interview was conducted with the DON (Director of Nursing) on 12/11/23 at 10:41 a.m. She indicated the CNAs (Certified Nursing Assistants) assist Resident K with care and if there were no glue for her dentures, they should tell supply to order some. An interview was conducted with LPN (Licensed Practical Nurse) 2 on 12/11/23 at 10:40 a.m. She indicated Resident K put her own dentures in and never said anything to her about not having any glue.			

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	An observation and interview was conducted with LPN 2 and Resident K on 12/11/23 at 10:42 a.m. LPN 2 went into Resident K's room to discuss her dentures. After exiting the room, LPN 2 indicated Resident K informed her she didn't like the facility's denture glue and wanted a specific brand. This was the first she'd heard of it, but would look into seeing if they could get her some. An interview and observation was conducted with Resident K on 12/11/23 at 10:51 a.m. She was not wearing her dentures. She indicated she needed someone to go shopping for her to get the type of denture glue she liked. If she could go shopping, she'd get her own. An interview was conducted with the DON on 12/11/23 at 2:55 p.m. She indicated she couldn't say anyone recognized Resident K wasn't wearing her dentures or addressed it. She hadn't noticed it and indicated she needed to be more observant. On 12/12/23 at 3:10 p.m., the DON provided the Showering a Resident policy, dated 10/2014, which read "...A shower will clean, refresh, and soothe the resident; stimulate circulation, and provide an opportunity for resident to exercise arms and legs... Resident will receive a shower at least twice weekly unless condition warrants otherwise or resident refuses... Equipment: towel, soap, washcloths..." This citation relates to Complaints IN00422769. 3.1-38(b)(1)			
F 0684 SS=D	483.25 Quality of Care			

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Bldg. 00	§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to administer a resident's medication, as ordered, and notify the medical provider of a resident's refusals of his medications to 2 of 5 residents reviewed for unnecessary medications. (Resident 15 and 17) Findings include: 1. The clinical record for Resident 17 was reviewed on 12/13/23 at 10:37 a.m. Her diagnoses included, but were not limited to, hypotension. There was no hypotension care plan included in Resident 17's care plans. The physician's orders indicated to administer one 5 mg tablet of midodrine two times a day for hypotension and to hold if systolic blood pressure is greater than 130, effective 4/9/23. The December, 2023 MAR (medication administration record) indicated the midodrine was not given on the following dates and times due to outside of parameters: 12/5/23 in the morning, 12/7/23 in the morning, 12/8/23 in the morning and evening, 12/12/23 in the morning, and 12/13/23 in the evening. The December, 2023 MAR and blood pressures	F 0684	**Quality of Care** Midodrine order for resident 17 was clarified for nurses when to give and when to hold. Blood pressures are being documented for each ordered administration. Care plan for hypotension and Hospice are now in place Resident 15 orders have been clarified. DON monitoring resident MAR for refusals. Staff educated on Refusal policy and procedures. Resident medication times reviewed and changed to better accommodate residents needs and wishes. All residents have potential to be affected by alleged deficient practices. DON to audit resident orders & MAR to ensure medications being given per orders and any refusals addressed. DON/designee to audit/monitor resident orders and MAR to ensure medications being given per orders and any refusals addressed. DON or Designee will audit on working days daily x 1 month; 3 times a week for 1 month and then	01/11/2024

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	from vitals did not have documented blood pressures for the following administration times: 12/5/23 morning, 12/8/23 morning and evening, 12/12/23 morning, and 12/13/23 in the evening. The 12/7/23 morning administration blood pressure was 110/66, which was not outside of parameters for administration. An interview was conducted with the DON on 12/13/23 at 12:19 p.m. She reviewed Resident 17's December, 2023 documented blood pressures and indicated the 12/7/23 morning dose of midodrine should have been given and there should be documented blood pressures for each ordered administration. She thought nursing may have been confused by the greater than sign in the orders and may need it written out instead. She indicated she did not see a hypotension care plan for her, but she should have one. 2a. The clinical record for Resident 15 was reviewed on 12/8/23 at 2:43 p.m. The resident's diagnosis included, but was not limited to, heart disease. A care plan dated 6/23/21 indicated Resident 15 was at risk for elevated blood pressure. The interventions included but was not limited to, give medications as ordered. A physician order dated 11/28/23 indicated the resident was to receive 5 milligrams of midodrine medication for hypotension three times a day. The staff was not to administer if the resident's systolic blood pressure was greater than 95. The order was discontinued on 12/11/23. A physician order dated 12/11/23 indicated the resident was to receive 5 milligrams of midodrine medication for hypotension twice a day. The staff was not to administer if the resident's systolic		weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	blood pressure was greater than 95. The December 2023 Medication Administration Record for Resident 15 indicated the following days the resident's systolic blood pressure readings were greater than 95, and the staff administered the 5 milligrams of midodrine: 12/1/23 - 6:00 a.m., - 121/65, 11:00 a.m. - 132/76, 9:00 p.m. - 125/75, 12/2/23 - 6:00 a.m., - 122/58, 12/3/23 - 6:00 a.m. - 136/78, 12/4/23 - 11:00 a.m. - 110/68, 12/5/23 - 6:00 a.m. - 110/74, 11:00 a.m. - 124/72, 12/6/23 - 6:00 a.m. - 129/68, 11:00 a.m. - 120/70, 9:00 p.m. - 118/68, 12/7/23 - 11:00 a.m. - 120/72, 12/8/23 - 11:00 a.m. - 132/70, 12/10/23 - 6:00 a.m. - 119/70, 12/11/23 - 6:00 a.m. - 112/65, 11:00 a.m. - 128/78, The evening of 12/11/23 - blood pressure reading was 132/78, and The morning of 12/12/23 - blood pressure reading was 130/70, An interview was conducted with the Director of Nursing on 12/12/23 at 2:42 p.m. She indicated the medical provider had decreased on 12/11/23, Resident 15's midodrine to twice a day. The DON had noticed during that meeting, the staff had not been administering the medication as ordered. 2 b. A care plan dated 12/6/21 indicated Resident 15 "...holds medications in mouth and doesn't swallow them. They are found later in bed..." The interventions put in place were the following: staff was to have resident sit up, open mouth after administration, ask if resident would like medications in applesauce, and praise if resident takes medications.			

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	A physician order dated 11/28/23 indicated the staff was to administer 7.5 milligrams of Olanzapine at bedtime for a diagnosis of Schizophrenia. A physician order dated 11/28/23 indicated the staff was to administer 150 milligrams of Zoloft daily for major depression. A physician order dated 11/28/23 indicated the staff was to administer 5 milligrams of Eliquis twice a day for heart failure. A physician order dated 11/28/23 indicated the resident was to receive 0.4 milligrams of flomax daily for urine retention. The December 2023 MAR indicated the following medications, days and times the resident had refused his medications: Flomax: 12/2/23, 12/3/23, 12/7/23, 12/9/23 and 12/10/23, Olanzapine: 12/2/23, 12/3/23, 12/4/23, 12/7/23, 12/9/23 and 12/10/23, and Zoloft: 12/3/23, 12/9/23 and 12/10/23 Eliquis: 12/2/23 - evening dose, 12/3/23 - morning and evening dosages, 12/4/23 - evening dose, 12/7/23 - evening dose, 12/9/23 - morning and evening dosages, and 12/10/23 - morning and evening dosages An interview was conducted with the Director of Nursing on 12/12/23 at 2:42 p.m. She indicated she was unaware of Resident 15's refusals of medications. The staff should have notified the medical provider of the refusals. 3.1-37(a)			

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F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to timely identify and treat pressure areas on a diabetic resident's feet. This failure resulted in unidentified pressure areas which caused pain for 1 of 1 resident randomly reviewed for pressure ulcers (Resident C). Findings include: The clinical record for Resident C was reviewed on 12/7/23 at 3:54 p.m. The Resident's diagnosis included, but were not limited to, diabetes with neuropathy (nerve pain) and renal failure. A Braden Scale for Predicting Pressure Sore Risk Assessment, completed 10/15/23, indicated Resident C was at moderate risk for skin breakdown. A Quarterly MDS (Minimum Data Set) Assessment, completed 11/2/23, indicated	F 0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer Resident C was seen by Nurse Practitioner and referred to wound care for evaluation of bilateral feet. Resident C continues to see Podiatry at regular visits. Facility wide skin sweep completed to ensure no other findings. Nursing staff educated on body assessments & documentation. Skin binder in place for documentation of weekly measurements of any skin areas All residents have potential to be affected by alleged deficiency Facility wide skin sweep completed to ensure no other findings. Nursing staff educated on body assessments & documentation.	01/11/2024

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	Resident C was cognitively intact, needed maximum assist with bathing, was dependent with lower body dressing, dependent with putting on and taking off his footwear, and received dialysis. A care plan, last reviewed 11/7/23, indicated that Resident C needed assistance with ADL (Activities of Daily Living). The goal was for him to remain clean, dry, and well groomed. The approaches included that he was dependent on staff to provide him with a bath twice weekly and as necessary, initiated 11/21/21, and that he required skin inspections daily with care. Observing for redness, open areas, scratches, cuts, bruises and report changes to the nurse. Skin assessment completed weekly by nurse, initiated 11/12/21. The clinical record did not contain a care plan related to the risk for skin breakdown. Total Body Skin Assessments had been completed in the EHR (Electronic Health Record) on 11/4/23, 11/10/23, 11/17/23, 11/24/23, 12/1/23, and 12/8/23 which indicated Resident C had no new wounds. During an interview on 12/13/23 at 10:38 a.m., Resident C indicated that his feet hurt. He had "area" on his heels. The facility was not treating the areas on his heels. He had told the staff that his heels hurt and had areas on them for at least a month and no one at the facility was doing anything about it. When his feet were touched the pain was "off the charts". On 12/13/23 at 10:40 a.m., Resident C's feet were observed with the DON (Director of Nursing) and LPN (Licensed Practical Nurse) 2. Resident C grimaced while LPN 2 removed his shoe and sock.		Skin binder in place for documentation of weekly measurements of any skin areas DON/designee will monitor weekly skin checks/wound measurements as well as do random skin sweeps to ensure all areas being addressed. Facility wide skin sweep completed to ensure all skin areas being addressed Nursing staff educated on body assessments & documentation. Skin binder in place for documentation of weekly measurements of any skin areas DON or Designee will audit on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	The left foot had a dark area on the heal which appeared black and leathery and measured 5 cm (centimeters) in length and 7.5 cm in width. Resident C visibly flinched when the area was touched. The DON indicated the area could be necrotic (dead tissue). The outside of the left foot had discoloration which measured 8 cm length and 1.5 cm which the DON described as a possible bruise or pressure area. The left great toe had blackened area which was 1 cm in length and 1.5 cm in width which the DON indicated could be a deep tissue injury. The right foot was observed to have a 4.5 cm in length by 5.5 cm in width black necrotic area which the DON indicated could be a scabbed deep tissue injury. The right lateral foot has a 2.5 cm in length by 1.5 cm in width dark brown round scabbed area which was present inside of an 8.5 by 3 cm area of discoloration. The right great toe had a 2 cm in length by 1.5 cm in width black area on the top of the toes which the DON described as a possible deep tissue injury. Resident C was observed to visible flinch and grimace when each area on his feet were touched. The DON and LPN asked resident C why he had not told them about the areas on his feet. Resident C indicated he thought he had told them because he had told everyone else. The DON and LPN 2 indicated they were not aware of any issues with Resident C's feet prior to observing them just then. LPN 2 indicated that the discolored areas on the outside of Resident C's right and left feet correspond with a raised area present on the outside of the footrests of Resident C's wheelchair where his feet usually were. On 12/13/23 at 11:40 a.m., NP (Nurse Practitioner) 7 was observed examining Resident C's bilateral feet. NP 7 indicated that Resident C's shoes had been rubbing his feet and that the areas could			

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RURAL HEALTH CARE CENTER	1747 N RURAL ST INDIANAPOLIS, IN 46218

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	have been caused by pressure from his shoes. Resident C was to be referred to wound care and podiatry. During an interview on 12/13/23 at 11:51 a.m., CNA (Certified Nursing Assistant) 4 indicated she had dressed Resident C that morning. CNA 4 had not noticed anything wrong with Resident C's feet, but she had not really looked specifically at his feet. On 12/13/23 at 12:10 p.m., the Regional Director provided the 8/30/23 podiatry exam which indicated Resident C had received diabetic foot care. the skin color on both feet was pale. There were callus present on Resident C's right and left great toes. All of the calluses were debrided/ pared to prevent further tissue breakdown and pain. The clinical record did not contain treatment orders for Resident C's feet. On 12/13/23 at 2:46 p.m., the DON provided the Skin Management Program policy, last revised 10/2013, which read "...This facility will assess/ identify the presence of risk factors that may contribute to the development of pressure ulcers and other skin alterations in an effort to prevent skin breakdown and / or further deterioration limited by the individual's recognized pathology and pre-existing co-morbid conditions...Residents who receive assistance with bathing and/ or peri-care will be observed daily by nursing staff for any observance of red areas, open area, skin tears, bruises, rashes, abrasions, excoriations or other alterations in skin will be reported to the licensed nurse for further assessment..." On 12/13/23 at 2:46 p.m., the DON provided the			

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	Skin Inspection policy, dated 10/2014, which read "... Nursing personnel shall inspect resident's skin upon admission and during provision of daily care in the effort to alert the licensed nurse of any indication of irritation or skin breakdown ...Check bony areas including...ankles, and heels for redness and warmth...report any unusual findings to the nurse immediately..." On 12/13/23 at 2:46 p.m., the DON provided the Pressure Ulcer policy, dated 10/2014, which read "...Pressure ulcers will be assessed and treated according to Skin Management Program...2. Assessment of pressure ulcers will be documented in the clinical record as per the Skin Management Program. 3. Treatment orders will be obtained...4. Ongoing measurements shall be obtained by a designated, qualified person. 5. Presence and/or risk for development of, pressure ulcers shall be included on the resident's care plan..." 3.1-40			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.			

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	§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on interview and record review, the facility failed to apply splints, as ordered by the physician, to the bilateral hands of a resident for 1 of 2 residents reviewed for limited range of motion (Resident G). Findings include: The clinical record for Resident G was reviewed on 12/7/23 at 10:51 a.m. The Resident's diagnosis included, but were not limited to, hemiplegia (paralysis) of the right-side and diabetes. A physician's order, dated 4/9/23, indicated Resident G was to wear resting pan hand splints on his bilateral hands each night at bedtime to decrease the chances of further contractures. The resident pan splints were to be removed each morning. A Quarterly MDS Assessment, completed 11/15/23, indicated he was cognitively intact, dependent on staff for full body bathing and dependent on staff for dressing and personal hygiene. A care plan, last reviewed 11/21/23, indicated that Resident G had contractures of his bilateral hands. The goal was for him to retain range of motion abilities. On 12/7/23 at 10:55 a.m., Resident G was observed in bed. There were 2 resting pan splints observed	F 0688	Increase/Prevent Decrease in ROM/Mobility Resident G's splints are being utilized Staff educated on splint placement and need Care plan added for Need/Use of splint All residents have potential to be affected by alleged deficiency Staff educated on splint placement and need Staff educated on splint policy and procedures DON/designee will monitor resident for splint placement and educate staff as needed. Therapy to educate nursing staff as needed DON or Designee will audit splint placement on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	01/11/2024

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	on a shelf. The fingers on his bilateral hands were curled in. He indicated he had splints to wear, but the staff did not put them on. The November and December 2023 Treatment Administration Record and Medication Administration Record were reviewed and did not contain information that the splints had been applied or removed. The clinical record did not contain a care plan for the use of the resting pan splints. During an interview on 12/12/23 at 11:23 a.m., the Director of Nursing indicated that splints should be applied as ordered by the physician. On 12/12/23 at 3:10 p.m., the Director of Nursing provided the Splinting Application policy, last revised 1/2015, which read "...Splint application designated to be completed by nursing personnel shall be documented by the applicable nurse aide... "			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized			

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	unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to monitor outputs for a resident with a catheter per the plan of care for 1 of 1 residents reviewed for catheter. (Resident 15) Findings include: The clinical record for Resident 15 was reviewed on 12/8/23 at 2:43 p.m. The resident's diagnosis included, but was not limited to, heart disease. A care plan dated 6/9/23 indicated the resident has a foley catheter. The intervention included but was not limited to, monitor and document intake and output. A physician order dated 11/28/23 indicated staff was to provide catheter care every shift.	F 0690	Bowel/Bladder Incontinence, Catheter, UTI Resident 15's output now being monitored Staff educated on recording output and importance All residents with catheters have potential to be affected by alleged deficiency Staff educated on recording output and importance Audit completed on residents with catheters to ensure appropriate measures are in place Staff educated on recording outputs and importance Audit completed on resident with catheters to ensure appropriate measures are in place	01/11/2024

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	The December 2023 urine output recording record indicated the following days and shifts the staff had not recorded urinary output for Resident 15: 12/1/23 - evening and night shift, 12/2/23 - day shift, 12/3/23 - day, evening and night shift, 12/4/23 - evening and night shift, 12/5/23 - day, evening and night shift, 12/6/23 - day shift, 12/7/23 - evening shift, 12/8/23 - day and night shift, 12/9/23 - evening and night shift, 12/10/23 - day and evening shift, 12/11/23 - evening shift, and 12/12/23 - night and evening An interview was conducted with the Director of Nursing on 12/12/23 at 3:45 p.m. She indicated after reviewing the input and output records, the staff should be documenting every shift. 3.1-41(2)		DON/designee to monitor output documentation and educate staff as needed DON or Designee will audit output documentation on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview and record review, the facility failed to address a resident's pain timely for 1 of 2 residents reviewed for pain. (Resident 18) Findings include:	F 0697	Pain Management Resident 18 has pain assessment ordered Q shift. Staff educated on nonpharmacological pain interventions, pain management, & importance of timely pain control	01/11/2024

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	The clinical record for Resident 18 was reviewed on 12/8/23 at 2:33 p.m. The resident's diagnosis included, but was not limited to, stroke. A care plan dated 11/18/23 indicated the resident was at risk for pain due to hemiplegia, depression and muscle spasms. The 10/30/23 Admissions MDS (Minimum Data Set) assessment indicated Resident 18 was cognitively intact. A physician order dated 4/9/23 indicated the resident was to receive a 3.1-6.10% salonpas patch every 12 hours as needed for back pain. A physician order dated 4/9/23 indicated the resident was to receive 4% of biofreeze for moderate pain twice a day. An observation was made of a medication administration to Resident 18 with Qualified Medication Aide (QMA) 8 on 12/11/23 at 8:37 a.m. During that time, Resident 18 had requested for a lidocaine patch. QMA 8 then left the resident's room and looked in the medication cart for a lidocaine patch for the resident. After, she returned back to the resident's room to report there was no lidocaine patches in the cart for her. QMA 8 then left Resident 18's room and returned back to the medication cart to pull the next resident's medications. There was no observation of QMA 8 asking Resident 18 if she was in pain and/or providing any nonpharmacological or medications to address her pain. An observation was made of obtaining blood sugar readings with QMA 8 on 12/11/23 at 11:30 a.m. Prior to obtaining a resident's blood sugar, Resident 18 had asked QMA 8 for biofreeze to be		measures All residents with pain have potential to be affected by alleged deficiency Pain Assessments completed on all residents Pain interventions audited for all residents Staff educated on nonpharmacological pain interventions, pain management, & importance of timely pain control measures DON/designee will monitor resident pain levels and interventions and complete random resident interviews to ensure pain being addressed DON or Designee will audit pain levels and interventions on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring	

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	applied on her lower back. The resident stated, "it hurts so bad. I need biofreeze on it." QMA 8 responded, "I'll get it in a minute." An interview was conducted with Resident 18 on 12/11/23 at 2:17 p.m. She indicated she still had not received the biofreeze for her back pain. The resident's back pain was a 7, utilizing a scale of 1 being the least amount of pain and 10 being the most amount of pain. An interview was conducted with the Director of Nursing on 12/11/23 at 2:19 p.m. She indicated QMA 8 had forgotten to apply the biofreeze to Resident 18's back earlier that day. The resident does not have an order for lidocaine patch, but does have an order for a salonpas patch to be applied for back pain if needed. A "Pain Management" policy was provided by the Director of Nursing on 12/11/23 at 3:33 p.m. It indicated "...This facility is committed to providing an environment and programs that assist each resident to attain and or maintain his/her highest practicable physical, mental, and psychosocial well being. It is the policy of this facility to monitor residents for signs and symptoms of pain and when identified, provide necessary assessment and interventions, according to the IDT (Interdisciplinary Team} plan of care, to achieve the highest practicable outcome...The resident will be assessed for pain...4. Pain status and effects of treatment will be monitored on a regular basis, e.g., during routine medication pass..." 3.1-37(a)			
F 0698 SS=D	483.25(l) Dialysis			

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Bldg. 00	§483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to perform pre and post dialysis assessments for a resident who received hemodialysis (Resident C). Findings include: The clinical record for Resident C was reviewed on 12/7/23 at 3:54 p.m. The Resident's diagnosis included, but were not limited to, diabetes with neuropathy (nerve pain) and renal failure. A physician's order, dated 10/12/23, indicated Resident C was to receive dialysis every Tuesday, Thursday, and Saturday. A physician's order, dated 10/12/23, indicated to check shunt for bruit (whooshing sound) and thrill (feeling of blood rushing) every shift. A Quarterly MDS (Minimum Data Set) Assessment, completed 11/2/23, indicated Resident C was cognitively intact, needed maximum assist with bathing, was dependent with lower body dressing, dependent with putting on and taking off his footwear, and received dialysis. A care plan, last reviewed 11/7/23, indicated that Resident C needed hemodialysis related to his renal failure. The goal was for him to have no signs and symptoms of complications of dialysis.	F 0698	Dialysis Resident C now receiving Pre/Post dialysis assessments Staff educated on assessments and importance All resident who receive dialysis have potential to be affected by alleged deficiency Staff educated on Pre/Post dialysis assessments and importance DON/designee will monitor Pre/Post dialysis assessments to ensure compliance DON or Designee will audit dialysis assessments on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	01/11/2024

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	The interventions included to encourage resident to go to scheduled dialysis appointments 3 times weekly, initiated 7/23/23, monitor, document, and report to md as needed signs or symptoms of infection to access site, initiated 7/26/23, obtain vital signs and weight per protocol, initiated 7/26/23. During an interview on 12/11/23 at 2:59 p.m., Resident C indicated that he went to dialysis every Tuesday, Thursday, and Saturday. He had a white binder that he took with him back and forth to dialysis. The nursing staff did not always monitor his dialysis shunt. During an interview on 12/12/23 at 11:27 a.m., the DON (Director of Nursing) indicated that Resident C's vital signs should have been done prior to and after he received dialysis and that his dialysis shunt should have been monitored each shift. A pre and post dialysis assessment should be documented under assessments in the electronic health record. On 12/11/23 at 12:15 p.m., the DON provided the vital signs record sheet for November and December 2023 from Resident C's white dialysis binder which indicated that vital signs had been done on the following dialysis days and times: 11/2/23 at 9:30 a.m.- pre-dialysis, 11/4/23 at 9:30 a.m.- pre-dialysis, 11/7/23 at 9:00 a.m., - pre- dialysis, 11/9/23 at 9:30 a.m.- pre-dialysis, 11/11/23 at 9:17 a.m., - pre-dialysis, 11/11/23 at 3:25 p.m.- post- dialysis, 11/13/23 at 9:30 a.m.- pre-dialysis, 11/14/23 at 11:22 a.m., - pre-dialysis, 11/16/23 at 9:00 a.m.- pre-dialysis, 11/16/23 at 3:02 p.m.- post- dialysis, 11/18/23 at 8:45 a.m.- pre- dialysis,			

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	11/18/23 at 3:30 p.m.- post dialysis, 12/7/23 at 10:29 a.m.- pre-dialysis, and 12/7/23 at 2:45 p.m.- post- dialysis. During an interview on 12/11/23 at 12:15 p.m., the DON indicated there were no pre or post dialysis assessments completed in the electronic health record. On 12/22/23 at 12:15 p.m., the DON provided the Dialysis Coordination/ Facility Services policy, dated 10/2014, which read "...3. Upon return from dialysis, resident's access site and physical status shall be evaluated by a licensed nurse with evaluation documented..." On 12/12/23 at 9:38 a.m., the DON provided the Dialysis, Renal procedure, revised 10/23/23, which read "...The Facility Licensed Nurse will perform a pre and post dialysis assessment on resident..." 3.1-37(a)			
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or			

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	fewer residents. Based on interview and record review, the facility failed to have a Registered Nurse on duty for 8 consecutive hours per day for 9 days during the months of April, May, and June 2023 with the potential to affect 33 of 33 residents residing at the facility. Findings include: On 12/7/23 at 3:10 p.m., the Director of Nursing provided the schedules, as worked, for the following dates: 5/7, 5/13, 5/14, 5/20, 5/21, 5/22, 5/27, 5/29, and 6/28/23. The provided schedules, as worked, did not include a Registered Nurse for 8 consecutive hours on those dates. On 12/13/23 at 3:18 p.m., the Director of Nursing provided the Departmental Supervision policy, last revised April 2006, which read "... A RN [Registered Nurse] shall be available in the facility, daily, for 8 consecutive hours each day..."	F 0727	RN 8 Hrs/7 days/Wk, Fullt Time DON Nursing schedules have been reviewed to ensure coverage of a Registered Nurse for 8 consecutive hours a day, 7 days a week. All residents have the potential to be affected by the same alleged deficient practice. Nursing schedules have been reviewed to ensure coverage of a Registered Nurse for 8 consecutive hours a day, 7 days a week. DON in-serviced on requirements of RN coverage. A Registered Nurse will be scheduled for 8 consecutive hours each day and will be used to fill shifts prior to other licensed nursing staff. DON/designee to review schedule as per audit tool and as needed. DON or Designee will audit schedules on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	01/11/2024
F 0732 SS=F Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily			

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	basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation and interview, the facility failed to ensure the postings of current daily working staff. This had a potential to effect 33 of 33 residents that reside in the facility.	F 0732	**Posted Nurse Staffing Information** Daily Nursing staff postings have been reviewed for accuracy and updated daily.	01/11/2024

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	155807	A. BUILDING 00 B. WING	12/14/2023

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	Findings include: Random observations were made of the facility on 12/7/23 at 9:45 a.m. and 3:00 p.m., 12/8/23 at 9:48 a.m. and 2:00 p.m., 12/11/23 at 10:15 a.m., 12/12/23 at 9:19 a.m. and 12:00 p.m. There were no postings of current daily working staff observed. An observation was made with Qualified Medication Aide (QMA) 8 of a wall by the nurse's station on 12/13/23 at 11:19 a.m. A plastic sleeve was observed hanging on that wall with nothing in it. QMA 8 indicated at that time, the daily working staff postings were to be placed in that plastic sleeve. The Director of Nursing (DON) was responsible for placing the postings in the sleeve on the wall. An interview was conducted with the DON on 12/13/23 at 11:22 p.m. She indicated she was the staff person to place the daily staff working postings in the sleeve on the wall. She had forgotten.		All residents have the potential to be affected by the same alleged deficient practice. Daily Nursing staff postings have been reviewed for accuracy and updated daily. Nursing staff in-serviced on requirements of daily nursing staff posting. Daily posting to be reviewed each shift to ensure accuracy and updated as needed. DON or Designee will audit staff postings on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on interview and record review, the facility failed to monitor behaviors and timely update care	F 0740	Behavioral Health Services Resident 13 no longer at facility.	01/11/2024

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	plans with new interventions for 2 of 6 residents reviewed for abuse and 1 of 1 resident reviewed for behaviors . (Resident 13, Resident H, and Resident 25) Findings include: 1. The clinical record for Resident 13 was reviewed on 12/7/23 at 3:19 p.m. The Resident's diagnosis included, but were not limited to, schizoaffective disorder and anxiety disorder. A care plan, initiated 2/23/23, indicated Resident 13 had episodes of physical aggression. The goal was for her not to harm herself or others. The interventions included to administer medications as ordered, initiated 2/23/23, analyze times of day, places, circumstances, triggers and what de-escalated behavior and document, initiated 2/23/23, give as many choices as possible about care and activities, initiated 9/27/23. A Quarterly MDS (Minimum Data Set) Assessment, completed 9/25/23, indicated she was cognitively intact and able to move around the facility independently. A care plan, initiated 9/27/23, indicated Resident 13 was easily angered. The goal was for her to remain free from injury and harm. The interventions included to be sensitive and cautious when approaching resident for care, initiated 9/27/23, develop a daily routine with consistency and structure keeping stress and demands low. Praise her for appropriate behavior, initiated 9/27/23, staff who work best with resident to care for her and work in pairs as able, initiated 9/27/23, and use direct communication and be concrete when speaking to her, initiated 9/27/23.		Resident H and resident 25's care plans and behavior monitoring sheets reviewed for accuracy. SSD educated on updating of behavioral care plans as needed/indicated. Staff educated on importance of documenting on behavior monitoring sheets Behavioral care plans audited for accuracy All residents have potential to be affected by alleged deficiency SSD educated on updating of behavioral care plans as needed/indicated. Staff educated on importance of documenting on behavior monitoring sheets SSD or designee to monitor resident behaviors/behavior sheets to ensure compliance and updated care plans as needed SSD or Designee will audit behavior notes/binder & care plans on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	Resident 13's clinical record contained a Health Status Note, dated 10/27/23, which indicated Resident 13 was very agitated that evening and coming out of her room wanting to "fight" other residents. A Behavior Note, dated 10/29/23, indicated Resident 13 had been verbally and physically abusive toward staff and peers. Resident 13 had come out of her room several times and threatened to others about being close to her room and attempted to hit another resident. Another resident at the facility had reported that Resident 13 had struck them. The clinical record did not contain an IDT (Interdisciplinary Team) note about the behavior incidents on 10/27/23 or 10/29/23. Resident 13's care plans had not been updated with new interventions related to the behaviors. During an interview on 12/11/23 at 12:51 p.m., the SSD indicated that many interventions had been attempted with Resident 13, such as giving her books to read and taking her outside to sit. The interventions that had been attempted should have been added to the care plan and monitored for effectiveness. 2a. The clinical record for Resident H was reviewed on 12/7/23 at 2:33 p.m. The resident's diagnosis included, but was not limited to, bipolar. The 9/6/23 Quarterly MDS (Minimum Data Set) assessment indicated Resident H was cognitively intact. A care plan dated 3/14/23 indicated the resident "has the potential to be physically aggressive toward staff/peers." An intervention included but			

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	was not limited to, "analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document." A care plan dated 4/4/22 indicated the resident "may voice allegations of mistreatment to caregivers..." 2b. The clinical record for Resident 25 was reviewed on 12/7/23 at 3:33 p.m. The resident's diagnoses included, but were not limited to, anxiety disorder, dementia with behavior disturbances and major depression disorder. The 10/24/23 Quarterly MDS (Minimum Data Set) assessment indicated Resident 25 was moderately impaired. A care plan dated 10/12/21 indicated Resident 25 "requires use of psychoactive meds R/T (related to) anxiety and depression. Receives antidepressant and antianxiety." The intervention included was not limited to, "If behavioral symptoms are observed record and document daily in the behavior log..." An interview was conducted with Resident H on 12/7/23 at 4:09 p.m. He indicated a couple of days ago, he was sitting in the dining room with a television remote. He had refused to give the television remote control to Certified Nursing Assistant (CNA) 4. The staff nor the residents that were present in the dining room liked the song that was playing on the television. CNA 4 grabbed his arm to get the remote from him. The investigation for the abuse allegation was provided by the Executive Director on 12/11/23 at 3:11 p.m. The file included the following:			

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	A written statement by CNA 4 indicated she did not grab Resident H's arm. Resident H and the other residents were sitting in the dining room. Resident H had the television remote and turned up the television to a loud volume. CNA 4 and the other residents asked him to turn it down. Resident H responded with no he would not turn it down. Resident 25 then got up and went over to Resident H to attempt to hit him. A written statement by License Practical Nurse (LPN) 2 dated 12/4/23 indicated "On above date this writer was in the dining room when [Resident 25] got up and approached [Resident H] because he would not turn the TV down. The two did not make contact at this time. [CNA 4] asked him to turn the TV down and that was all that transpired." An interview was conducted with the Executive Director (ED) and Regional Director (RD) on 12/11/23 at 4:05 p.m. The ED indicated the incident in the dining room between CNA 4 and Resident H regarding a remote control was witnessed and investigated. CNA 4 did not put her hands on Resident H. Resident 25 nor CNA 4 grabbed or hit Resident H. The residents' behaviors should have been placed in the behavior monitoring book. The behavior monitoring book was reviewed with the RD on 12/11/23 at 4:15 p.m. Resident H's behavior management record did not indicate the resident had a behavior on 12/4/23. Resident 25's behavior management record was reviewed. The resident's record did not indicate a behavior type he had on 12/4/23. On 12/11/23 at 10:40 a.m., the ED provided the Behavioral Assessment, Intervention and Monitoring policy, revised 2/2019, which read...			

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	The facility will provide and residents will receive behavioral health services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care...The interdisciplinary team will thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes, and address any modifiable factors that may have contributed to the resident's change in condition...The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident and develop a plan of care accordingly...If the resident is being treated for altered behavior or mood, the IDT will seek and document any improvements or worsening in the individual's behavior, mood and function..." 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.			

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	§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to ensure availability of medication for administration for 1 of 5 residents reviewed for unnecessary medications, 1 of 1 resident reviewed for vision services, and 1 of 6 residents reviewed during administration of medication observations. (Residents K, 18, and 34) Findings include: 1. The clinical record for Resident K was reviewed on 12/7/23 at 2:50 p.m. Her diagnoses included, but were not limited to: type 2 diabetes mellitus, Alzheimer's disease, schizoaffective disorder, chronic kidney disease, and vascular dementia. The 1/14/20 diabetes care plan indicated an intervention was to provide diabetes medication as ordered by the doctor. The 11/9/23 Annual MDS (Minimum Data Set) assessment indicated she had a BIMS (brief	F 0755	Pharmacy Srvcs/Procedures/Pharmacist/Records Resident K's glyburide order reviewed for accuracy and re-ordered from pharmacy. Resident now receiving correct dose per orders. Staff educated on Medication administration Resident 34's MAR reviewed and Eye doctor made aware of eye drops that were not given as per order r/t late arrival from pharmacy. Staff educated on Medication administration/ordering policy & procedures Resident 18's Norco reordered. Staff educated on reordering of medication timely and to report to DON any delays in receiving medications All residents have potential to be affected by alleged deficiencies	01/11/2024

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	interview for mental status score) of 15, indicating she was cognitively intact. An interview was conducted with Resident K on 12/7/23 at 2:56 p.m. She indicated she took gliburide, but she'd some administrations, because it took 2 days to come in from the pharmacy. The physician's orders indicated to administer two 5 mg tablets of gliburide twice a day (a total of 4 tablets a day) for type 2 diabetes, starting 11/29/23. This The December, 2023 MAR (medication administration record) indicated she was not administered the 12/5/23 evening dose of gliburide due to pending arrival from pharmacy. An interview was conducted with the DON (Director of Nursing) on 12/11/23 at 10:24 a.m. She indicated the only problem they had with getting medications from pharmacy was that staff sometimes ordered the medications too soon, which caused pharmacy to deny the request. She implemented a process that if a resident missed any of their medications, the nurse had to call pharmacy to ask if it could be sent and then had to call her so she could override and get it paid for. Staff was pretty good about doing that. An observation of the Resident K's gliburide in the medication cart was made with LPN (Licensed Practical Nurse 2 and the DON on 12/11/23 at 10:32 a.m. There was one 12 tablet card with a delivery date of 12/5/23 with 2 remaining tablets. LPN 2 indicated the medication was not in their emergency drug kit. The DON reviewed the pharmacy history portal for Resident K's gliburide order. It indicated 12		Staff educated on medication administration/ordering policy & procedures and to report to DON any delays in receiving medications; DON/designee will perform random audits on resident medications to ensure they have arrived from pharmacy and have been reordered timely. DON/designee to educate nursing staff and ensure medications being ordered timely. DON or Designee will audit random resident medications on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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tabs were delivered on 11/30/23, enough to last 3 days, and 12 tabs were delivered on 12/6/23, enough to last 3 more days. The DON indicated there was not enough gliburide delivered to the facility for Resident K to have received 4 tablets a day since 11/30/23. It was possible staff was only administering one tablet instead of two per administration. "That'd be my best guess."

2. The clinical record for Resident 34 was reviewed on 12/7/23 at 3:00 p.m. His diagnoses included, but were not limited to, cataract.

The 9/27/23 Admission MDS (Minimum Data Set) assessment indicated he was cognitively intact.

An interview was conducted with Resident 34 on 12/7/23 at 3:10 p.m. He indicated he had cataract surgery on his right eye and was supposed to get eye drops 4 times a day, but normally only received them twice a day.

The physician's orders did not include any current orders for eye drops.

The 11/2/23 Eye Drop Schedule post right eye surgery for Resident 34 was provided by the DON (Director of Nursing) on 12/12/23 at 9:38 a.m. It indicated to administer one drop of Prednisolone Acetate 1% 4 times a day for 3 weeks through 11/23/23, then one drop 2 times a day for 2 weeks through 12/7/23; one drop of Prolensa 0.07% one time a day for 3 weeks through 11/23/23; and one drop of Ofloxacin 0.3% 4 times a day for 1 week through 11/9/23. It read, "Please start all eye drops today, at the above times."

The November, 2023 MAR (medication administration record) indicated the Prolensa 0.07% was not administered on 11/3/23, 11/4/23 or

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	11/6/23 due to pending arrival from pharmacy. It indicated the Ofloxacin 0.3% was not administered once on 11/6/23 due to pending arrival from pharmacy. An interview was conducted with the DON on 12/11/23 at 2:55 p.m. She reviewed Resident 34's orders and MAR and indicated she understood the unavailability the eye drops was a concern. There was a process in place for nursing to use when a resident's medications were unavailable. 3. The clinical record for Resident 18 was reviewed on 12/8/23 at 2:33 p.m. The resident's diagnosis included, but was not limited to, stroke. A care plan dated 11/18/23 indicated the resident was at risk for pain due to hemiplegia, depression and muscle spasms. A physician order dated 8/4/23 indicated Resident 18 was to receive 5-325 milligrams of norco twice a day. The December 2023 Medication Administration Record (MAR) indicated the following days, shifts and administrations of Resident 18's norco pain medication: 12/8/23 - evening dose - resident refused, 12/9/23 - morning dose administered, and evening dose not available, 12/10/23 - morning dose administered and evening dose not available, During a medication administration observation with Qualified Medication Aide (QMA) 8 on 12/11/23 at 8:37 a.m., she indicated Resident 18's 5-325 milligrams of norco was not available to give to her this morning. Medications are to be ordered when they get as low as 8 dosages left. The			

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	medical provider was probably needing to give a script to continue the order. An interview was conducted with the Director of Nursing on 12/11/23 at 3:50 p.m. She indicated she was unaware of Resident 18's norco was not available until this morning. The resident had been out of norco the whole weekend, and she was not made aware. The norco was on its way from the pharmacy. A controlled medication record for Resident 18's 5-325 milligrams of norco was provided by the Director of Nursing on 12/12/23 at 11:26 p.m. It indicated the resident's last administration of 5-325 milligrams of norco was on Friday, 12/8/23 at 9:00 a.m. The Medication Administration policy was provided by the DON on 12/11/23 at 11:42 a.m. It read, "PURPOSE: To Safely administer mediations as per physicians' orders." 3.1-25(a) 3.1-25(b)			
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			

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	and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure open or expired dates were placed on insulin pens after opening and timely discarding 10 CC (cubic centimeter) syringes that were expired for 1 of 1 medication storage rooms and 1 of 2 medication carts reviewed. (Resident 8 and Resident G) Findings include: 1. The clinical record for Resident 8 was reviewed on 12/8/23 at 2:33 p.m. The resident's diagnosis included, but was not limited to, diabetes mellitus. A physician order dated 12/8/23 indicated the resident was on a sliding scale of novolog. The sliding scale was the following: 150 - 200 blood sugar readings = 2 units of insulin, 201 - 250 blood sugar readings = 4 units of insulin, 251 - 300 blood sugar readings = 6 units of insulin, 301 - 350 blood sugar readings = 8 units of insulin, 351 - 400 blood sugar readings = 10 units of	F 0761	Label/Store Drugs and Biologicals Resident 8's Novolog Flexpen was labeled with open/expired date. Resident G's Humalog flex pen was labeled with open date/expired date. All boxed or bagged medications and inhalers were labeled with resident name and administration directions. All insulins and medications audited for correct labeling to include resident name, administration directions, and date opened as applies. Expired syringes removed from Medication storage room and room audited to ensure no further expired items. All residents have the potential to be affected by the same alleged deficient practice. All insulins and medications audited for correct labeling to include resident name, administration directions, and date opened as applies. Storage room	01/11/2024

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	insulin, 401 - 450 blood sugar readings = 12 units of insulin, An observation was made of insulin administration with License Practical Nurse (LPN) 2 on 12/11/23 at 11:30 a.m. LPN 2 was observed administering 6 units of novolog to Resident 8. The novolog flex pen was observed with no open and/or expired date. During that time, an observation was made of the medication cart with LPN 2. A humalog flex pen was observed in the medication cart for Resident G with no open and/or expired date. An interview was conducted with LPN 2 at 12/11/23 at 11:35 a.m. She indicated all opened insulin pens should have an open date and/or expiration date. 2. An observation was made of the medication storage room with LPN 2 on 12/13/23 at 2:00 p.m. There was a box of 10 CC syringes observed. LPN 2 indicated there was forty-one 10 cc syringes with an expired date of 4/1/23. LPN 2 at that time indicated she was discarding the expired syringes. An interview was conducted with the Director of Nursing on 12/13/23 at 2:30 p.m. She indicated the pharmacy was just in and audited. 3.1-25(j)(k)(6)(o)		reviewed to ensure no further expired items Nursing staff in-serviced on requirements of labeling drugs and biologicals. Audits on medication carts/medication storage room to be completed per DON/designee as indicated on audit tool. DON or Designee will audit medication carts and medication storage on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources			

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	approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure the kitchen was clean and in good repair, the staff contained their hair in the kitchen, cell phones were not plugged into the walls with clean dishes or on food prep areas, and food was labeled, dated and not expired. This had a potential to effect 33 of 33 residents that eat food prepared in the kitchen. Findings include: An observation was made of the kitchen with the Dietary Manager (DM) on 12/7/23 at 11:00 a.m. The DM had a hairnet covering the crown and 1/2 way down her head, but the sides and the back of her hair was not contained in the hairnet. The kitchen flooring was observed with food and dirt debris along the back walls behind the appliances. There were loose floor tiles under the compartment sink, and the back wall behind the ice machine had crumbling concrete and missing base board trim. The bottom corner wall by the	F 0812	Food Procurement, Store/Prepare/Serve-Sanitary Dietary Manager was educated on proper hairnet usage. Kitchen floor clean of dirt/debris. Loose tiles under compartment sink, back wall by ice machine and trim, and bottom corner wall by dry food storage area repaired. White boards framing air conditioner in kitchen cleaned, window sealed and gaps addressed. Cell phone removed from kitchen area, ceiling cleared of dust/debris, rag on toaster discarded Items in freezer/refrigerator and dry storage area are now labeled/dated, freezer items checked for bag integrity to ensure not opened to air, Cleaning logs located and	01/11/2024

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	dry food storage area had broken tiles. The kitchen window that contained a window air conditioner was observed with a black trash bag covering it with gray duck tape. White boards framed both sides of the window air conditioner that had brown and black substance on it. The window was not sealed, and the outside was observed through gaps with cool air coming in from it. A clean dish rack was observed with a cell phone plugged in by a cord attached to the wall on a shelf with the clean dishes. The DM indicated at the time the cook needed a free outlet to charge his phone. The ceiling above the food prep area had dust hanging from the ceiling, and 1 rag with a brown substance on it was sitting on top of the toaster. The DM indicated at that time, the rag was from scrubbing the stove that day. One stand alone freezer was observed with 4 frozen pizzas. There was no label or date on them. The 2nd stand alone freezer was observed with 1 paper bag of fries and 1 bag of broccoli with slices in the bags causing the fries and the broccoli to be opened to air. 1 plastic bag of tenderloins, 1 plastic bag of chicken nuggets, and 1 plastic bag of breaded Brussels sprouts had no label or date on them. A plastic bag was observed with an orange white substance with no label what was contained in the bag. The DM indicated it was sweet potatoes rice. The refrigerator was observed with 1 fruit salad container with expired date of 11/24/23, 2 sour cream containers with expired date of 11/22/23, 1 opened Caesar salad dressing container top lid was not sealed with no open date. The dry storage area was observed with the following food items not labeled or dated: 1 bottle of barbecue sauce, 1 bottle of sweet sour sauce, 2 packages of country gravy, and 2 packages of noodles. A syrup bottle 1/4 full was observed with dry drippings of syrup on the sides of the bottle. The DM indicated at that time the		reviewed for accuracy All resident have potential to be affected by alleged deficiencies. Kitchen deep cleaned and repairs being made. Kitchen staff educated on cleaning, sanitary environment, dating/labeling, and hair nets. Cleaning logs reviewed for accuracy. Administrator will perform audits on kitchen cleanliness, dating/labeling of food items, hair nets, cleaning logs, and repair. Administrator or Designee will audit on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	syrup bottle should be thrown away. An interview was conducted with the DM on 12/7/23 at 11:15 a.m. She indicated all food items should be labeled and dated. Expired food items should be discarded. An observation was made of the kitchen with the DM on 12/11/23 at 9:34 a.m. The DM was observed with a hairnet on, but the sides and the back of her hair was not contained in the hairnet. The floor tiles under the compartment sink were loose and not attached. The corner bottom wall by the dry storage area had missing tiles, and the window air conditioner was observed with a black trash bag with duck tape on it. White boards framed both sides of the unit that had a brown and a black substance on it. The outside could be seen through gaps and air could be felt. The back wall behind the ice maker had crumbling cement and missing bottom base board trim. The kitchen floor was observed with food and dirt debris behind the appliances, and the ceiling above the food prep area had dust hanging from the ceiling. During an observation in the kitchen with the DM on 12/11/23 at 12:12 p.m., a personal cell phone was observed in the food prep area plugged in by a cord on the wall. The ceiling above the food prep area was observed with dust hanging from the ceiling. An interview was conducted with the Executive Director (ED) on 12/13/23 at 11:48 a.m. He indicated the floor tiles had been repaired, but the kitchen had a leak and the tiles came undone. He could purchase a window kit to seal the window. Cleaning logs were not provided at the time of exit on 12/14/23.			

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	A "Food Preparation and Service" policy was provided by the ED on 12/11/23 at 3:30 p.m. It indicated "...Food service employees shall prepare and serve food in a manner that complies with safe food handling practices...7. Dietary staff shall wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food..." A "Food Receiving and Storage" policy was provided by the ED on 12/11/23 at 3:30 p.m. It indicated "...Food shall received and stored in a manner that complies with safe food handling practices...1. Food Services, or other designated staff, will maintain clean food storage areas at all times...7. All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date)..." A hair restraints policy was provided by the ED on 12/11/23 at 3:30 p.m. It indicated "...Hair restraints shall be worn by all dietary employees while working in the kitchen area..." 3.1-21(i)(1)(2)(3)			
F 0814 SS=F Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure trash was covered by a lid in the kitchen area. This had a potential to affect 33 of 33 residents that eat food prepared in the kitchen. Findings include: Observations were made of the kitchen on 12/7/23 at 11:00 a.m., and 12/11/23 at 9:34 a.m. The kitchen	F 0814	Dispose Garbage and Refuse Properly Kitchen trash cans now have lids covering them All residents have potential to be affected by alleged deficiency. Kitchen trash cans now have lids covering them and will be monitored to ensure on going compliance	01/11/2024

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	trash can was observed full to the top with food and paper products with no lid covering. An interview was conducted with the Executive Director on 12/13/23 at 11:48 a.m. The ED indicated the trash should be contained with a lid. The "Disposal of Garbage" policy was provided by the Executive Director on 12/11/23 at 3:30 p.m. It indicated "...It is necessary that all garbage and refuse be handled in such a manner as to prevent cross-contaimination, transmission of disease or rodent/insect breeding areas. Procedure: 1. Containers shall be easily cleaned, shall be provided with tight-fitting lids,.." 2.1-21(5)		Administrator or designee will monitor trash to ensure can remain covered with lids. Administrator or Designee will audit trash can lids on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	
F 0851 SS=F Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical			

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	environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.	F 0851	Payroll Based Journal	01/11/2024

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	Based on interview and record review, the facility failed to accurately submit the data for license personnel that worked in the facility from April 2023 through June 2023 to CMS (The Centers for Medicare & Medicaid Services) for the Payroll Based Journal Daily Nurse Staffing (PBJ) report. This had a potential to effect 33 of 33 residents that reside in the facility. Findings include: The PBJ Staffing Data Report that was generated from April 2023 through June 2023 indicated the following days the facility did not have license personal working in the building: 4/2/23, 4/9/23, 4/16/23, 4/23/23, 5/7/23, 5/14/23, 5/21/23, 5/22/23, 6/10/23, 6/11/23, 6/17/23, 6/25/23, 6/28/23, 6/29/23, and 6/30/23. On 12/7/23 at 3:10 p.m., the Director of Nursing provided the schedules, as worked, for the following dates: 4/2/23, 4/9/23, 4/16/23, 4/23/23, 5/7/23, 5/14/23, 5/21/23, 5/22/23, 6/10/23, 6/11/23, 6/17/23, 6/25/23, 6/28/23, 6/29/23, and 6/30/23. The schedules as worked indicated a licensed nurse had worked in the facility for each of the 3 shifts daily. During an interview on 12/13/23, the Director of Nursing indicated there had been a licensed nurse in the building for each shift. She was unaware of who was responsible for completing the PBJ report and reporting the information to CMS.		Schedules to be reviewed for accuracy prior to submitting for PBJ All staff in-serviced on the importance of scheduling accuracy Admin, DON, BOM in-serviced on submitting accurate payroll based staffing information to CMS by RDO. All residents have potential to be affected by alleged deficient practices. Administrator or designee will verify daily staffing sheet and an audit will be conducted to ensure the licensed nursing hours have been captured and will continue to audit going forward. Administrator or designee will verify daily staffing sheet and An audit will be conducted to ensure the licensed nursing hours have been captured and will continue to audit going forward. Administrator or Designee will audit staffing licensed nurse hours on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	
F 0867 SS=D Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems			

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	and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse			

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	events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their			

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	causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. Based on interview and record review, the facility	F 0867	QAPI/QAA Improvement Activities	01/11/2024

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	failed to implement a corrective plan of action for pressure ulcers. This affected 1 of 1 resident reviewed for pressure ulcers and had a potential to affect 33 of 33 residents residing at the facility. Findings include: An interview was conducted with the Executive Director on 12/13/23 at 4:15 p.m. He indicated QAPI (Quality Assessment and Performance improvement Program) met monthly. One deficiency that was identified during this recertification and complaint survey on 12/7/23 through 12/14/23, was cited at harm level - F686 - G. Pressure Ulcers: 1 resident was found to have unidentified pressure areas on his bilateral feet. There was no evidence the facility had developed or implemented an appropriate action plan with measures to correct the deficiency that was cited. Cross reference F686 An interview was conducted with the ED and DON on 12/13/23 at 4:15 p.m. The DON indicated in October 2023 she had identified a concern with the completion of residents' skin assessments and pressure ulcers. A skin sweep was done and new orders for skin assessments were implemented. A QAPI plan had not been developed for the identified concern. On 12/8/23 at 10:00 a.m., the ED provided the Quality Assurance and Performance Improvement (QAPI) Committee policy, dated 7/2016, which read "...The primary goals of the QAPI committee		The facility will ensure an effective QAPI program is in place to identify systemic, reoccurring, and/or trending issues with the day to day operations of the facility, This alleged, deficient practice had the potential to affect all residents. The Administrator has been educated by the RDO/Designee on the Facility QAPI process and expectations involved, including identifying systemic, reoccurring and/or trending issues as well as taking minutes at each meeting and review of concerns. The RDO/Designee will attend and/or review the minutes from the QAPI meetings for the next 6 months to ensure an effective QAPI program is in place. The RDO will provide the Administrator with guidance as needed.	

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	are t0...Help identify actual and potential negative outcomes relative to resident care and resolve them appropriately...Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals...Coordinate and facilitate communication regarding the delivery of quality resident care within and among departments and services, and between facility staff, residents, and family members..." 3.1-52			
F 0880 SS=F Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;			

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	§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to ensure infection control was maintained during medication administration observations with hand hygiene and touching of pill medications with bare hands and failed to implement and maintain a water management policy and procedure to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in the facility's water system for 4 of 6 residents observed during medication administrations. (Residents' 1, 15, 18, and 28) and the potential to affect 33 of 33 residents residing at the facility. Findings include: 1. An observation was made of Qualified Medication Aide (QMA) 8 administering medications to Resident 1 on 12/11/23 at 8:20 a.m. QMA 8 was observed pulling and preparing medications for Resident 1. Prior to preparing the medications, she had walked to the vending machine and purchased a pop for Resident 1. She then returned back to the medication cart and started pulling medications from the cart for Resident 1. During that time, QMA 8 was observed touching medication cart drawers, medications cards, personal cell phone, computer, plastic sleeves, pill crusher and keys. She then grabbed a capsule out of the medication cup of pills with her bare hands and placed the capsule on top of medication cart. After crushing the remaining pills, QMA 8 then picked up the capsule and pulled it apart and poured the pill powder into the medication cup of crushed pills.	F 0880	Infection Prevention & Control The facility will ensure infection prevention and control measures are in place and staff educated on hand hygiene during medication administration. The facility will follow it's water management program and test as determined necessary. The DON/IP Nurse will educate staff on hand hygiene and perform handwashing audits. The IP nurse will meet with the maintenance director to discuss the facility water management program and findings. The facility will follow it's Water Management Program and makes observations and test as indicated per the program. All residents at risk from these alleged, deficient practices. Staff have been educated on handwashing policy and procedures Maintenance Director in serviced by Admin/Designee on the Facility Water Management Program; including observations and testing per the requirements of the plan. DON/Designee will observe 2 medication administrations on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months.	01/11/2024

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	She indicated at that time, the capsule was the resident's iron medication and was unable to be crushed. QMA 8 was observed touching the resident's hands while providing him his pop and administering the crushed medications in applesauce. QMA 8 had not used hand hygiene prior, during or after pulling and preparing medications. An observation was made of QMA 8 administering Resident 15's medication on 8/11/23 at 8:29 a.m. QMA 8 was observed pulling and preparing pill medications for Resident 15. She then administered the medications to the resident. She had not used hand hygiene prior, during or after preparing the resident's medications. An observation was made of QMA 8 administering medications to Resident 18 on 12/11/23 at 8:37 a.m. Prior to preparing the resident's medications QMA 8 had moved yellow wet floor signs in the hallway and moved her cart down the hall. She then pulled and prepared Resident 18's medications. During that time, she was observed popping pill medications from the medication cards into her bare hands and placing in the medication cup. QMA 8 did not utilize hand hygiene before or after pulling and preparing the resident's medication. An observation was made of QMA 8 administering medications to Resident 28 on 12/11/23 at 8:47 a.m. QMA 8 was observed pulling and preparing as needed medications for Resident 28. During that time, she was observed popping pill medication from the medications cards into her bare hands. QMA 8 was not observed utilizing hand hygiene prior, during or after administration of medications.		Non-compliance will be corrected immediately. The Administrator will meet with the Maintenance Director monthly to ensure that the Protocol for the Water Management Program is being followed. This will continue indefinitely. Non compliance will be corrected immediately. The Admin/DON/Designee will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	An interview with the Director of Nursing on 12/11/23 at 3:50 p.m. She indicated the nursing staff should not be handling pill medications with their bare hands and should be utilizing hand hygiene after each resident contact. 2. A Legionella Water Management Program policy was received on 12/12/23 at 3:59 p.m. from Executive Director (ED). The policy indicated, "As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team...The purposes of the water management program are to identify area in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease...The water management program includes the following elements: a. An interdisciplinary water management team; b. A detailed description and diagram of the water system in the facility, including the following: 1. Receiving; 2. Cold Water Distribution; 3. Heating; 4. Hot water distribution; and 5. Waste. c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including: 1. Storage tanks; 2. Water heaters; 3. Filters; 4. Aerators; 5. Showerheads and hoses; 6. Misters, atomizers, air washers and humidifiers; 7. Hot tubs; 8. Fountains; and 9. Medical devices such as CPAP machines, hydrotherapy equipment; etc. d. The identification of situations that can lead to Legionella growth, such as:			

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	1. Construction; 2. Water main breaks; 3. Changes in municipal water quality; 4. The presence of biofilm, scale or sediment; 5. Water temperature fluctuations; 6. Water pressure changes; 7. Water stagnation and; 8. Inadequate disinfection. e. Specific measures used to control the introduction and/or spread of Legionella..., f. The control limits or parameters that are acceptable and that are monitored; g. A diagram of where control measures are applied; h. A system to monitor control limits and the effectiveness of control measures; i. A plan for when control limits are not met and/or control measures are not effective; and j. Documentation of the program. 6. The Water Management Program will be reviewed at least once a year, or sooner if any of the following occur: a. The control limits are consistently not met; b. There is a major maintenance of water service change; c. There are any disease cases associated with the water system; or d. There are changes in laws, regulations, standards or guidelines. An interview with ED conducted on 12/12/23 at 4:19 p.m. indicated, when asked to provide the detailed description and diagram of the water system for the facility; the identification of areas in the facility's water system that had been identified where potential growth and spread of bacteria could occur; the specific measures the facility used to control the introduction and/or spread of Legionella; a diagram where control measures were applied; the system used to			

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	monitor the control limits and their effectiveness; and what the control limits and parameters are acceptable, he was unable to provide such information for the facility. Instead, a sample of another facility's management plan for Legionella was provided as an example of an outside service which created, monitored, and documented the inspections, tests and measurements which the facility was interested in obtaining. A "Hand Hygiene" policy was provided by the Director of Nursing on 12/11/23 at 3:33 p.m. It indicated "...This facility considers hand hygiene the primary means to prevent the spread of infections...7. Use an alcohol-based hand rub containing atleast 62% alcohol; or, alternately, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; c. Before preparing or handling medications,...i. After contact with a resident's skin,..." 3.1-18(b) 3.1-18(l)			
F 0887 SS=D Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education			

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	regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine			

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	or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). Based on interview and record review, the facility failed to ensure residents who wanted to have the COVID-19 booster vaccine were administered in a timely manner for 4 of 5 residents reviewed for immunizations. (Residents B, D, 30 and 31) Findings include: A clinical record review for Resident's 12, 4, 30, and 31 conducted on 12/12/23 at 10:05 a.m. indicated, these residents had not received the COVID-19 booster vaccine. An interview with Resident 30 conducted on 12/12/23 at 1:16 p.m. indicated, he would like to have the COVID-19 booster vaccine. An interview with Resident B conducted on 12/12/23 at 1:18 p.m. indicated, she would like to have the COVID-19 booster vaccine. An interview with Resident D conducted on 12/12/23 at 1:27 p.m. indicated, she would like to have the COVID 19-booster vaccine. A file folder containing COVID-19 booster vaccine consents was received on 12/12/23 at 2:06 p.m. from DON (Director of Nursing). An interview with DON conducted at the same time indicated, the consents in the file folder had not been uploaded into the residents' charts as of yet. The file contained, but not limited to, signed COVID-19 booster vaccine consents for the following residents and the date the consent was signed:	F 0887	COVID-19 Immunization All residents have been offered COVID booster, consents or declinations have been uploaded and booster given to those who wanted to receive it. DON/designee will continue to educate residents who refused booster and offer it again each month. All resident have potential to be affected by alleged deficient practices DON will audit and monitor immunizations to ensure residents are up to date and consents received. DON or Designee will audit random resident charts on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	01/11/2024

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	Resident B on 11/15/23 and Resident D on 11/15/23. Residents 30 and 31 did not have signed consents or declinations. An interview with DON conducted on 12/12/23 at 3:27 p.m. indicated, she believes they haven't completely finished asking residents if they would like the COVID-19 booster vaccination as of yet, no COVID-19 boosters have been administered, and the attempt to order COVID-19 booster vaccines from a pharmacy had not happened as of yet. A COVID-19 Vaccination policy and procedure was received on 12/11/23 at 3 p.m. from DON. It indicated, "Educating Staff and Residents on the COVID-19 vaccine...COVID-19 vaccinations will be offered to all staff and residents...All staff and residents/representatives will be educated on the COVID-19 vaccine they are offered, in a manner they can understand...Residents/representatives will be provided the opportunity to refuse the vaccine and/or change their decision about vaccination at any time...Documenting COVID-19 Vaccine for Staff and Residents The facility will maintain documentation for all residents...on COVID-19 vaccination, including the primary series, boosters and additional doses...For residents, the information will be documented in their medical record...The information to be documented includes: The staff person, resident or representative was provided education regarding the benefits and potential risks, associated with COVID-19 vaccine. Whether the...resident of their representative consented to the vaccine..." A Vaccination of Residents policy received on 12/11/23 at 3 p.m. from DON indicated, "All residents will be offered vaccines that aid in			

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	preventing infectious diseases unless the vaccine is medically contraindicated, or the resident has already been vaccinated." The CDC (Centers for Diseases and Control) website located at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/ltcf-residents.html , last accessed on 12/12/23, "COVID-19 Vaccines for Long-term Care Residents" last updated Sept. 25, 2023 indicated, "CDC recommends everyone aged 5 years and older, including people who live and work in Long-term Care (LTC) settings, get 1 updated COVID-19 vaccine... People who are moderately or severely immunocompromised can get additional updated COVID-19 vaccines...People who live in LTC settings must give consent, or agree to getting a COVID-19 vaccine." 3.1-18(b)(5)			
F 0919 SS=D Bldg. 00	483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. Based on observation, interview, and record review, the facility failed to ensure all portions of their resident call system was properly functioning for 1 of 33 residents in the facility. (Resident B) Findings include:	F 0919	Resident Call System Resident B's call system inspected and light bulb was needing replaced. Facility located light bulb to replace it with and light now functioning.	01/11/2024

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	An observation of Resident B's room was made on 12/7/23 at 2:39 p.m. When pulled, the call light in the bathroom sounded at the nurses station, but did not light up above the door to be seen from the hallway. An environmental tour of the facility was conducted with the ED (Executive Director) and MS (Maintenance Supervisor) on 12/12/23 at 2:30 p.m. The MS pulled Resident B's bathroom call light. It did not light up above her door. The MS indicated the bulb needed to replace the current blown bulb was discontinued and no longer in production. He looked online at various sites and contacted the facility's supply company for a replacement bulb. He stated, "It's so old, it can't be replaced." The whole system needed replaced. The Call Light policy was provided by the ED on 12/13/23 at 3:48 p.m. It read, "Call lights must remain functional and within reach of each resident."		All residents have potential to be affected by alleged deficiency. Maintenance Director educated on performing audits and inspections on call light system Staff educated on filling out work orders when deficiency noted Adminor Designee will audit random call lights on working days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	
F 0924 SS=F Bldg. 00	483.90(i)(3) Corridors have Firmly Secured Handrails §483.90(i)(3) Equip corridors with firmly secured handrails on each side. Based on observation, interview, and record review, the facility failed to equip corridors with firmly secured handrails for 33 of 33 residents in the facility. Findings include: An observation was made on 12/8/23 at 10:34 a.m. The handrail near the activity office was not securely affixed to the wall and was protruding from the wall. A resident was propelling himself in his wheel chair near the activity office. He	F 0924	Corridors have Firmly Secured Handrails Handrails in the corridors are being inspected by corporate maintenance for integrity and repairs being made as needed All residents have potential to be affected by alleged deficiency. Maintenance/ED educated on Handrail safety by RDO ED or Designee will audit handrails/progress on working	01/11/2024

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RURAL HEALTH CARE CENTER	1747 N RURAL ST INDIANAPOLIS, IN 46218

(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
	grabbed the handrail with his right hand to assist him along, and the handrail pulled even further from the wall. An observation of the handrails throughout the facility was made on 12/11/23 at 3:56 p.m. The end part of the handrail, when approaching a doorway, was missing outside of Resident K's room and Resident 30's room. The handrails were loose and not firmly secured to the wall outside of Resident 8's and 20's room and outside of Resident 9's and 23's room. An environmental tour was conducted with the ED (Executive Director) and MS (Maintenance Supervisor) on 12/12/23 at 2:30 p.m. Observations of the facility handrails were made. The handrail near the activity office was pulled further from the wall to the point the screw and bracket of part of the handrail had come through the drywall. The end part of the handrail, when approaching a doorway, was still missing outside of Resident K's room and Resident 30's room. The handrails were still loose and not firmly secured to the wall outside of Resident 8's and 20's room and outside of Resident 9's and 23's room. An interview was conducted with the MS on 12/12/23 at 2:30 p.m. during the tour after observation of the handrails. He indicated the missing parts of the handrail were handrail caps that had broken and fallen off so many times they were unable to be put back on. He'd contacted the facility's supply company about the handrail caps, but the caps had been discontinued and were no longer in production. He was unaware of the loose handrails throughout the facility. The Maintenance Service policy was provided by the ED on 12/13/23 at 3:48 p.m. It read, "1. The		days daily x 1 month; 3 times a week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring.	

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	Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: ...b. Maintaining the building in good repair and free from hazards." 3.1-19(f)(3)			
F 0925 SS=F Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview and record review, the facility failed to ensure the facility was free of flying insects. This had a potential to affect 33 of 33 residents that resident in the facility. Findings include: An observation was made of Resident G in his room on 12/07/23 at 10:53 a.m. Flying gnats were observed flying in his room. The resident swiped at one of the gnats attempting to land on his left ear. Resident G indicated he has reported the gnats, but the staff indicated there was nothing they can do about it. An observation was made of the kitchen with the Dietary Manager (DM) on 12/7/23 at 11:00 a.m. The kitchen was observed with the back door standing wide open, loose tiles under the 3-compartment sink, and the trash can was full of food and paper products with no lid covering. The kitchen window that contained a window air conditioner was observed with a black trash bag covering it with gray duck tape. White boards framed both sides of the window air conditioner that had brown and black substance on it. The	F 0925	Maintains Effective Pest Control Program Resident G's room treated for flying insects. Cleaning procedures reviewed with staff to ensure nothing in room to attract insects. DM educated on keeping back door closed, loose tiles under sink being repaired, trash can now has lid, air conditioner ad window area sealed, Resident j's room treated for flying insects. Cleaning procedures reviewed with staff to ensure nothing in room to attract insects. All residents have potential to be affected by alleged deficient practices. Pest control continues to come to building. Pest control measures in place and being followed Audits to be conducted to ensure ongoing compliance by Administrator/designee on working days daily x 1 month; 3 times a	01/11/2024

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	window was not sealed, and the outside was observed through gaps with a cool air coming in from it. During that time, a flying gnat was observed flying in the kitchen area. An observation was made of Resident G in her room on 12/7/23 at 2:39 p.m. A gnat was observed flying in her room. She indicated she has no idea how they get in here. An observation was made of Resident J in her room on 12/7/23 at 3:04 p.m. A gnat was flying around the room. The resident indicated at that time, if she leaves her meal tray in the room too long gnats are all over the tray. During an observation of medication administration on 8/11/23 at 8:20 a.m., an observation of gnats flying in the dining room and hallway. An observation was made of the kitchen with the DM on 12/11/23 at 9:34 a.m. The floor tiles under the 3-compartment sink were observed to be loose and not attached. The window air conditioner was observed with a black trash bag with duck tape on it. White boards framed both sides of the unit that had a brown and a black substance on it. The outside could be seen through gaps and air could be felt. The trash was full with food and paper products with no lid covering. A flying gnat was flying in the kitchen area. A pest control invoice dated 9/29/23 indicated loose tiles under kitchen sink and air conditioner needs sealed and leaks fixed. An interview was conducted with the Executive Director (ED) on 12/13/23 at 11:48 a.m. He indicated the floor tiles had been repaired. The		week for 1 month and then weekly x 4 months The Admin and/or DON will report the findings to the QAPI meeting monthly for review. After 6 months, the IDT will determine the need and /or frequency of continued monitoring	

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	kitchen recently had a leak and the tiles came undone. He could purchase a window kit to seal the window. A "Pest Control Program" policy was provided on 12/11/23 at 4:00 p.m. by the Director of Nursing. It indicated "...It is the policy of this facility to maintain an effective pest control program to ensure the facility is free of pests and rodents. The "Disposal of Garbage" policy was provided by the Executive Director on 12/11/23 at 3:30 p.m. It indicated "...It is necessary that all garbage and refuse be handled in such a manner as to prevent cross-contaimination, transmission of disease or rodent/insect breeding areas. Procedure: 1. Containers shall be easily cleaned, shall be provided with tight-fitting lids,.." 31.-19(f)(4)			