STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155520	A. BUILDING 00 B. WING	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF RIVER CITY	909 NORTH FIRST AVE EVANSVILLE, IN 47710

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 8, 9, 10 & 11, 2024 Facility number: 000437 Provider number: 155520 AIM number: 100273770 Census Bed Type: SNF/NF: 27 Total: 27 Census Payor Type: Medicare: 6 Medicaid: 17 Other: 4 Total: 27 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 22, 2024.	F 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted October 8-11, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of November 11, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on interview and record review, the facility failed to notify the physician and resident representative when residents left the facility independently for 2 of 3 residents reviewed for elopement. (Resident 22, Resident 75) Findings include:	F 0580	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts	11/11/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
April Haggerty	Int. Administrator	11/01/2024

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	1. On 10/9/24 at 2:12 P.M., Resident 22's guardian indicated staff should contact her every time the resident left the facility. On 10/4/24 she let the facility know that it was ok for the resident to leave on Mondays, Wednesdays, and Fridays and did not need to be contacted on those days. On 10/9/24 at 9:12 A.M., Resident 22's clinical record was reviewed. Diagnoses included, but were not limited to, schizophrenia and stimulant dependence. Resident 22 was admitted to the facility on 9/13/24. The most current Admission Minimum Data Set (MDS) Assessment, dated 9/20/24, indicated Resident 22 had no cognitive impairment and was independent in all Activities of Daily Living (ADLs). A Letters of Temporary Guardianship document, dated 8/29/24, indicated Resident 22 was assigned a court-appointed guardian. An Admission Elopement Risk Assessment, dated 9/13/24, indicated Resident 22 was at low risk for elopement. On 10/9/24 at 11:30 A.M., an elopement binder was observed on the 300 hall nurses station desk. The binder indicated Resident 22 was at risk for elopement. The binder included, but was not limited to, Resident 22's picture, name, date of birth, room number, physician name, and emergency contact name. The emergency contact listed was the court-appointed guardian. A physician order, dated 10/1/24, indicated that the resident had a state guardian and was not permitted to go outside and smoke or leave the facility unless approved by the guardian.		alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1) Resident # 22 no longer resides at the facility: therefore, no further corrective action could be taken for this resident. 2) Resident # 75's Leave of Absence (LOA) order was updated on October 9, 2024, to read "Resident may go out on therapeutic leave with medications." 2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? Residents with orders for LOA with supervision have the potential to be affected by the cited practice. AN audit of physician orders has been conducted to identify those residents who require supervised LOA's. The care plans of those residents identified will be reviewed and revised, as necessary. 3.) What measures will be put into place and what systemic changes	

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	An Ineffective Coping care plan, dated 9/18/24, included an intervention to ensure the resident's safety. The clinical record lacked a care plan related to the court-appointed guardian or elopement risk. A Release Of Responsibility For Leave Of Absence (LOA) document indicated the resident signed herself out of the facility on the following dates: 9/18/24 at 11:33 A.M. 9/18/24 at (illegible time) 9/18/24 at 5:10 P.M. 9/18/24 at 7:00 P.M. 9/19/24 at 3:50 P.M. 9/19/24 at 6:10 P.M. 10/3/24 at 1:30 P.M. A Nursing Progress note, dated 10/7/24 at 6:26 P.M., indicated the resident left the facility independently and returned "weak". The clinical record lacked documentation that the guardian or the physician was notified that Resident 22 signed herself out of the facility on 9/18/24, 9/19/24, 10/3/24, and 10/7/24. On 10/9/24 at 12:30 P.M., the Director of Nursing (DON) indicated that the former administrator had allowed staff to take the resident outside to smoke to appease her complaining. The facility was aware she had a guardian since she was admitted. The physician order was entered on 10/1/24 to make staff aware the resident was not to leave without guardian approval and to safeguard the resident from leaving at night on her own. It was changed to Mondays, Wednesdays, or Fridays, but the DON was not sure when that was		will be made to ensure that the deficient practice does not recur? Licensed nursing staff and Social Services Director (SSD) have been re-educated relative to Notification of Changes, including and not limited to, notifying physicians and resident representatives when residents who require supervision leave the facility independently. 4.) How the corrective action(s) will be monitored? Director of Nursing Services (DNS), Social Services Director (SSD), or designee will review LOA logs 5 days a week for 1 month and 3 days a week for 5 months to identify any LOA's that required resident representative and/or physician notification, and to ensure notifications have been made, and that documentation relative to LOAs is complete and accurate. Any identified concerns will promptly be addressed with the responsible individual(s). The results of these audits will be reviewed in Quality Assurance Monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Completion date: November 11,	

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	changed. The Social Service Director (SSD) was supposed to document that information, but the DON was unable to find any documentation related to the change of LOA approval. On 10/9/24 at 2:50 P.M., SSD indicated that from 9/13/24 to 9/30/24, Resident 22 was not to leave the facility under any circumstances. Between 9/30/24 and 10/4/30, the guardian changed her mind many times about when the resident could leave the facility. On 10/4/24, the guardian agreed to let Resident 22 go out on independent LOA on Mondays, Wednesdays, and Fridays from 1:30 P.M. to 2:30 P.M. The resident was to check in with the SSD when she left and came back. She indicated the resident had been doing that, but the SSD was not documenting those occurrences. At that time, she indicated a social service progress note, detailing the conversations with the guardian from admission to current had been entered in the clinical record on 10/9/24 at 1:24 P.M. The SSD was unable to provide documentation from conversations with the guardian before 10/9/24. On 10/10/24 at 1:40 P.M., the DON indicated that the guardian and physician were not notified when the resident left the facility sheet. The former administrator approved the resident to sign out to smoke with staff without approval from guardian. All notifications to the guardian and physician should be documented in a progress note. 2. On 10/09/24 at 7:33 A.M., Resident 75's clinical record was reviewed. Diagnoses included, but were not limited to, muscle weakness, need for assistance with personal care, and muscle wasting. The most current 5 Day Admission MDS		2024	

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	(Minimum Data Set) Assessment, dated 10/6/24, indicated that the resident was cognitively intact and was dependent on staff for transfer, dressing, hygiene, and mobility. Physicians orders included, but were not limited to: May go on LOA (Leave of Absence) with responsible party PRN (as needed), dated 9/29/24. A Release Of Responsibility For Leave Of Absence document indicated the resident signed himself out of the facility on the following dates: 10/3/24 at 12:47 P.M. 10/8/24 at 1:00 P.M. The document contained five signatures that did not specify a date or time and were illegible. The clinical record lacked documentation that the physician was notified when the resident left independently and without a responsible party. Interview on 10/10/24 at 1:36 P.M., the DON (Director of Nursing) indicated the order needed to be modified to indicate the resident could go LOA on his own. On 10/9/24 at 11:55 A.M., the DON provided a current Guidelines for LOA policy, dated 6/2023, that indicated "A sign-out log should be available for the resident or responsible party to sign out prior to leaving campus for a leave of absence". On 10/9/24 at 3:55 P.M., the DON provided a current Wandering and Elopement policy, dated 8/2022, that indicated "A list of residents at risk for elopement is maintained in a binder with corresponding pictures ... When the resident returns to the facility, the Director of Nursing Services or Charge Nurse will...contact the			

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	attending physician and report findings and conditions of the resident; notify the resident's legal representative...". On 10/10/24 at 9:13 A.M., the DON provided a current Adult Guardianship in Indiana: The Basics policy, dated 8/23/2018, that indicated "unless limited by the court, a guardian is responsible for providing or supervising the protected person's care...". On 10/11/24 at 8:30 A.M., the Administrator provided a current Change in a Resident's Condition or Status policy, dated 8/2024, that indicated "The nurse will notify the resident's physician or physician on call when there has been a...discharge without proper medical authority". 3.1-5(a)(3)			
F 0635 SS=D Bldg. 00	483.20(a) Admission Physician Orders for Immediate Care Based on observation, interview, and record review, the facility failed to ensure a resident had orders upon admission for their PICC (peripherally inserted central catheter), wound care, management of their wound vac, and an order for enhanced barrier precautions for 1 of 1 resident reviewed for infection control. (Resident 225) Finding includes: On 10/9/24 at 11:40 A.M., Registered Nurse (RN) 9 was observed preparing vancomycin 750 milligrams (mg) / 150 milliliters (mL) to administer to Resident 225. A sign on the door indicated the resident was on enhanced barrier precautions (EBP). RN 9 did not donn a gown prior to caring	F 0635	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.) What corrective action(s) will	11/11/2024

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	for the resident. RN 9 flushed the first lumen on Resident 225's PICC line with 10 mL of saline and then flushed the second lumen on the PICC line with 8 mL of saline. RN 9 hooked the vancomycin to the PICC line and set the medication to run at 150 drops per minute. At that time, a wound vac was observed on the resident's coccyx. On 10/9/24 at 1:53 P.M., Resident 225's clinical record was reviewed. Resident 225 was admitted to the facility on 10/5/24. Diagnoses included, but were not limited to, osteomyelitis (infection in the bone). Current physician orders included, but were not limited to: Vancomycin HCl intravenous solution (antibiotic), 750 mg intravenously two times a day for infectious wound related to osteomyelitis, dated 10/7/24. Vancomycin trough (lab work that is checked to monitor levels of Vancomycin in blood stream), CBC (complete blood count), CMP (comprehensive metabolic panel), one time only for IV (intravenous) antibiotics for 1 day, dated 10/8/24. Assess IV site every shift for signs and symptoms of infection or infiltration every shift, dated 10/6/24. The clinical record lacked orders for saline flushes through Resident's PICC line, order for PICC line, wound vac orders and wound care, and enhanced barrier precautions or transmission-based precautions related to Resident's wound and PICC line. Current care plans for Resident 225 included, but were not limited to: I have a venous access device specify: picc,		be accomplished for those residents found to have been affected by the deficient practice? RN # 9 was re-educated at the time of survey relative to Enhanced Barrier Precautions (EBP). Necessary physician orders for Resident # 225 pertaining to the PICC line and precautions were obtained at the time of the survey. 2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All newly admitted residents have the potential to be affected by the cited practice. Thus, this plan of correct applies to all residents newly admitted to the facility. 3.) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses have received re-education relative to Admission Physician Orders for Immediate Care, including but not limited to, ensuring all necessary physician orders are present (e.g., wound care, IV care, infection control, etc). 4.) How the corrective action(s) will be monitored? DNS, or designee, will be	

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	midline, Peripheral IV related to antibiotics, date initiated 10/5/2024. If Resident has swelling or increased pain during infusion, stop IV and notify provider, date initiated 10/5/2024. IV assessment as indicated, date initiated 10/5/2024. Labs as ordered, date Initiated 10/5/2024. Notify provider for signs and symptoms of infection, extravasation, infiltration, increased pain, date initiated 10/5/2024. Treatments as ordered, date initiated 10/5/2024. I am receiving IV (intravenous) medications for: osteomyelitis and cellulitis (skin infection), date initiated 10/5/2024. An admission skilled nursing note, dated 10/6/24, indicated that Resident 225 had a power injection catheter in right chest and wounds on the left gluteal fold, right gluteal fold, coccyx, and left toe. Initial wound measurements were: Left gluteal fold 6 cm (centimeters) x 2 cm x 0.2 cm Right gluteal fold 3 cm x 1.5 cm x 0.2 cm Coccyx wound vac in place Left toe 1.2 cm x 0.1 cm x 0.1 cm. On 10/10/24 at 12:41 P.M., the Director of Nursing indicated orders for PICC, enhanced barrier precautions, and wound care should have been put in upon admission. She indicated a resident with a PICC line should have basic orders related to the PICC line including saline flushes, infection prevention caps covering the lumens of the PICC, and wounds should have treatment orders. A Physician Services policy, provided by Regional Support on 10/11/24 at 10:01 A.M., indicated "once a resident is admitted, orders for the resident's immediate care and needs... provided by physician, physician assistant, nurse		responsible for auditing the charts of all new admissions the day following the admission for 1 month to ensure all necessary physician orders are present. Thereafter, the DNS, or designee, will be responsible for auditing the charts of all new admissions within 3 days of admission for 5 months to ensure all necessary physician orders are present. Any identified concerns will be promptly addressed with the responsible individual(s). The results of these audits will be reviewed in Quality Assurance Meetings monthly x 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5.) Completion Date: November 11, 2024	

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	practitioner, or clinical nurse specialist". 3.1-30(a)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to ensure accurate Minimum Data Set (MDS) assessments were completed for a resident with Post Traumatic Stress Disorder and intravenous access and residents with falls for 1 of 1 residents reviewed for antibiotic use and 2 of 2 residents reviewed for falls. (Resident 21, Resident 10, Resident 2) Findings include: 1. On 10/8/24 at 2:32 P.M., Resident 21's clinical record was reviewed. Resident 21 was admitted on 8/9/24. Diagnoses on admission included, but were not limited to, osteomyelitis, Post Traumatic Stress Disorder (PTSD), and borderline personality disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/25/24, indicated Resident 21 was cognitively intact, did not have PTSD, and did not have IV (intravenous) access. A current care plan, dated 9/19/24, indicated (Resident) received IV Medications related to osteomyelitis of right foot, Date Initiated: 9/19/24. During an interview on 10/10/24 at 12:41 P.M., the Director of Nursing (DON) indicated the MDS Assessment should have indicated Resident 21 did have a diagnosis of PTSD and did have IV access at the time of the MDS Assessment on 9/25/24.	F 0641	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1.) Resident #21 had Modification of the Quarterly MDS and Modification of the State Optional-Other completed on 10/10/24 to ensure accuracy of the assessments. 2.) Resident #10 had Modification of the Quarterly MDS and Modification of the State Optional-Other completed on 10/10/24 to ensure accuracy of the assessments. 3.) Resident #2 had Modification of the Quarterly MDS and	11/11/2024

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	2. On 10/9/24 at 9:37 A.M., Resident 10's clinical record was reviewed. Resident 10 was admitted on 7/24/23. Diagnoses included, but were not limited to, generalized muscle weakness and abnormality of gait and mobility. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/27/24, indicated Resident 10 was cognitively intact. Resident 10 required substantial assistance (staff perform more than half of the work) for toileting, bathing, and transfers. The MDS Assessment indicated no falls since the prior MDS Assessment on 6/27/24. A transfer to hospital summary, dated 7/20/2024 at 10:03 A.M., indicated Resident 10 experienced an unwitnessed fall resulting in a large hematoma on the back of her head, and was transported to the hospital. During an interview on 10/10/24 at 12:41 P.M., the Director of Nursing (DON) indicated the MDS Assessment should have indicated Resident 10 experienced a fall between the previous and most recent MDS Assessment. 3. On 10/9/24 at 12:22 P.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, repeated falls, hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, and symptoms and signs involving cognitive functions and awareness. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 9/13/24, indicated Resident 2 was mildly cognitively impaired, required partial assistance of staff (staff does less than half) with hygiene and dressing, and had no falls since the prior assessment on 6/14/24.		Modification of the State Optional-Other completed on 10/14/24 to ensure accuracy of the assessments. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents who have PTSD, IV access, and who have sustained falls have the potential to be affected. An audit has been conducted to identify residents with these conditions. This plan of correction applies to those residents identified. The MDS' of these residents have been reviewed to ensure accuracy with modifications completed and submitted, as necessary. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The MDS Coordinator has been re-educated relative to Accuracy of Assessments, including but not limited to, ensuring diagnoses, IVs, and falls are codded accurately on the MDS. 4. How the corrective action(s) will be monitored? DNS, or designee, will audit completed MDS's 3 times per	

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	Physician's orders included, but were not limited to: Bilateral side rails to promote bed mobility every shift, dated 4/8/24. Activity Level: WBAT (Weight Bearing as Tolerated), dated 4/8/24. The current falls care plan indicated that Resident 2 was at risk for falls/injury due to impaired mobility and history of falls, dated 4/8/24. Interventions included, but were not limited to: encourage staff to assist with transfer and ADL (Activities of Daily Living), footwear to prevent slipping, and anticipate and meet the resident's needs. A nursing progress note, dated 7/19/24 at 1:24 P.M., indicated the resident had an unwitnessed fall without injury in her room. During an interview on 10/10/24 at 3:41 P.M., the DON (Director of Nursing) indicated the resident was not coded for falls on the Quarterly MDS Assessment dated 9/13/24 and should have been. On 10/11/24 at 8:30 A.M., Regional Support provided a policy titled Resident Assessment, dated 8/24, that indicated "Assessments are completed by the staff members who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's strengths and areas of decline. Information in the MDS assessment will consistently reflect information in the progress notes, plan of care, and resident observations/interviews".		week for 1 month, then f2 times per week for 1 month, and weekly thereafter for 4 months, to ensure residents' diagnoses, IV's, and falls are accurately coded. Any identified concerns will be promptly addressed with the MDS Coordinator. The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Completion Date: November 11, 2024	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan			

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	Based on observation, interview, and record review, the facility failed to ensure a resident had a baseline care plan related to their wounds and wound management for 1 of 1 residents reviewed for infection control. (Resident 225) Finding includes: On 10/9/24 at 11:40 A.M., a wound vac was observed on Resident 225's coccyx. On 10/9/24 at 1:53 P.M., Resident 225's clinical record was reviewed. Resident 225 was admitted to the facility on 10/5/24. Diagnoses included, but were not limited to, osteomyelitis (infection in the bone). An admission skilled nursing note, dated 10/6/24, indicated that Resident 225 had a power injection catheter in right chest and wounds on the left gluteal fold, right gluteal fold, coccyx, and left toe. Initial wound measurements were: Left gluteal fold 6 cm (centimeters) x 2 cm x 0.2 cm Right gluteal fold 3 cm x 1.5 cm x 0.2 cm Coccyx wound vac in place Left toe 1.2 cm x 0.1 cm x 0.1 cm. The clinical record lacked baseline care plans for 4 of 4 of Resident 225's documented wounds, as well as management with a wound vac the resident had in place. On 10/10/24 at 12:41 P.M., the Director of Nursing indicated care plans were updated immediately and as needed. On 10/11/24 at 8:30 A.M., the Administrator provided a Care Plane, Comprehensive Person-Centered policy, dated 8/2024, that indicated "The comprehensive, person-centered	F 0655	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #225s care plan was updated to reflect the wound and wound treatment on 10/12/24. 2.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All newly admitted residents have the potential to be affected by the cited practice. Thus, this plan of correction applies to all residents newly admitted to the facility. 3.) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?	11/11/2024

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	care plan ...describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ...". 3.1-30(a)		Licensed nurses responsible for completion of the Baseline Care Plans have been re-educated relative to ensuring all pertinent resident conditions are addressed on the Baseline Care Plan. 4.) How the correction action(s) will be monitored? DNS, or designee, will be responsible for auditing the charts of all new admissions the day following the admission for 1 month, then within 48 hours of admission for 5 months to ensure all pertinent resident conditions are addressed on the Baseline Care Plan. Any identified concerns will be promptly addressed with the responsible individual(s). The results of these audits will be reviewed in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Completion Date: November 11, 2024	
F 0657 SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision			

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Bldg. 00	Based on record review and interview, the facility failed to ensure care plans were revised for 2 of 3 residents reviewed for accidents. Care plans were not revised after falls, substance misuse, and determination of elopement risk. (Resident 2, Resident 22) Findings include: 1. On 10/9/24 at 12:22 P.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, repeated falls, hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, and symptoms and signs involving cognitive functions and awareness. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 9/13/24, indicated Resident 2 was mildly cognitively impaired, required partial assistance of staff (staff does less than half) with hygiene and dressing, and had no fall since the prior assessment. Physician's orders included, but were not limited to: Bilateral side rails to promote bed mobility every shift, dated 4/8/24. Activity Level: WBAT (Weight Bearing as Tolerated), dated 4/8/24. The current falls care plan indicated that Resident 2 was at risk for falls/injury due to impaired mobility and history of falls, dated 4/8/24. Interventions included, but were not limited to: Anticipate and meet the resident's needs, initiated on 4/8/24 Set up craft station in room, initiated on 6/14/24. An incident note, dated 6/29/24 at 1:00 P.M.,	F 0657	This Plan of Correction is the center's credible allegations of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice? 1.) Resident # 2's fall prevention care plan was reviewed and revised on 10/10/24. 2.) Resident # 22 no longer resides at the facility: therefore, no further corrective action could be taken for this resident. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? Residents who have sustained falls in the last 60 days, who are at risk for elopement, and who have substance abuse concerns have the potential to be affected by this cited practice. Audits have	11/11/2024

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	indicated Resident 2 had an unwitnessed fall. The care plan was not updated with a new intervention. A nursing note, dated 7/19/24 at 1:24 P.M., indicated Resident 2 had an unwitnessed fall. The care plan was not updated with a new intervention. A nursing note, dated 9/22/24 at 4:32 P.M., indicated Resident 2 had an unwitnessed fall. The care plan was not updated with a new intervention. During an interview on 10/10/24 at 2:25 P.M., the Director of Nursing (DON) indicated that the care plans needed to be updated after each fall. 2. On 10/9/24 at 9:12 A.M., Resident 22's clinical record was reviewed. Diagnoses included, but were not limited to, schizophrenia and stimulant dependence. The most current Admission Minimum Data Set (MDS) Assessment, dated 9/20/24, indicated Resident 22 had no cognitive impairment, had no behaviors, and was independent in all Activities of Daily Living (ALDs). A current history of substance abuse (methamphetamines) care plan, dated 9/14/24, included the following interventions: Encourage verbalization of feelings, fears, and anxiety. Labs as ordered. Medications as ordered. Review facility policy on substance abuse with resident/responsible party and ensure they understand consequences of not following facility policy. Therapy evaluation as needed.		been conducted to identify the residents who fit these categories, their care plans have been reviewed and revised, as necessary, to ensure interventions are current and appropriate. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nursing staff, MDS Coordination and the Interdsciplinary Team (IDT) have received re-education relative to Care Plan Timing and Revision, including but not limited to implementing and/or updating a resident's care plan to ensure fall prevention interventions are current, elopement risk is addressed, and substance abuse is appropriately addressed. 4.) How the corrective action(s) will be monitored? DNS, or designee, will be responsible for auditing the care plans of 3 residents daily for 2 weeks to ensure all pertinent resident conditions are addressed. Thereafter, the DNS, or designee, will be responsible for auditing the care plans of at least 3 residents per week for 5 1/2 months to ensure all pertinent resident conditions are addressed. Any identified concerns will be	

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	A Social Services progress note, dated 9/27/24 at 11:39 A.M., indicated a Certified Nursing Aide (CNA) notified the Social Service Director (SSD) and Director of Nursing (DON) that Resident 22 and another resident were seen crushing a white substance in a baggy. The white substance was found hidden in the resident's deodorant container. Law enforcement was called. An officer tested the substance upon arrival and it tested positive for methamphetamine. Resident 22 admitted to using the drug but would not say how long she had the drugs in her possession or where she got them. The care plan was not updated following the incident with methamphetamines or law enforcement on 9/27/24. On 10/9/24 at 11:30 A.M., an elopement binder was observed on the 300 hall nurses station desk. The binder indicated Resident 22 was at risk for elopement. The binder included Resident 22's picture, name, date of birth, room number, physician name, and emergency contact name. The clinical record lacked a care plan related to Resident 22's elopement risk. On 10/9/24 at 11:50 A.M., the Director of Nursing (DON) indicated that all residents in the elopement binder should also have a care plan. On 10/10/24 at 9:04 A.M., the DON indicated the care plan was not updated following the incident with the methamphetamine and law enforcement on 9/27/24. On 10/11/24 at 8:45 A.M., the Regional Support indicated there was no substance abuse policy.		promptly addressed with the responsible individual(s). The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Completion date: November 11, 2024	

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	That policy was retired the first week of September and was not replaced. The care plan was not updated to reflect that change. On 10/9/24 at 3:55 P.M., the DON provided a current Wandering and Elopements policy, dated 8/2022, that indicated "Care plans will be developed and individualized for residents who are at risk of elopement. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety". On 10/11/24 at 8:30 A.M., the Administrator provided a current Care Plans, Comprehensive Person-Centered policy, dated 8/2024, that indicated "Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change". 3.1-35(a) 3.1-35(d)(1) 3.1-35(e)			
F 0658 SS=E Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards Based on interview and record review, the facility failed to ensure insulin was given in accordance with professional standards for 5 of 5 residents reviewed for insulin. Residents were given insulin late and by unqualified staff. (Resident 18, Resident 1, Resident 17, Resident 11, Resident 8) Findings include: 1. On 10/9/24 at 10:06 A.M., Resident 18's clinical record was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus.	F 0658	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely	11/11/2024

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	The most current Quarterly Minimum Data Set (MDS) Assessment, dated 7/22/24, indicated Resident 18 had no cognitive impairment and received insulin. Physician orders included, but were not limited to: Humalog (insulin lispro - a short-acting insulin) KwikPen Subcutaneous Solution Pen-injector 100 unit/mL (milliliters) - Inject as per sliding scale: if 0 - 140 = 0 units; 141 - 180 = 2 units; 181 - 240 = 4 units; 241 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 600 = 12 units subcutaneously before meals and at bedtime for type 2 diabetes mellitus, dated 7/11/24 The September 2024 Medication Administration Record (MAR) indicated that Resident 18 received 8 units of insulin lispro on 9/23/24 at 7:30 A.M. by Qualified Medication Aide (QMA) 2. On 10/9/24 at 1:49 P.M., employee files were reviewed. QMA 2's license did not include insulin administration certification. On 10/10/24 at 12:52 P.M., the Director of Nursing (DON) indicated QMAs were not allowed to administer insulin. 2. On 10/10/24 3:23 P.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 8/13/24, indicated Resident 1 had severe cognitive impairment and received insulin. Physician orders included, but were not limited to: Lantus SoloStar (insulin glargine - a long-acting		because it is required by the provision of federal and state law. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1., 2., 3., 4., & 5. Resident #'s 18, 1, 17, 11. & 8 had no negative outcome related to the cited practice. Qualified Medication Aide (QMA) #21 and RN # 21 were addressed at the time of survey relative to ensuring proper documentation of medications. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents receiving insulin have the potential to be affected by the cited practice. An audit has been conducted to identify those residents' receiving insulin, this plan of correction applies to those residents identified. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nursing staff and QMA's have been re-educated relative to Services Provided Meet Professional Standards, including	

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	insulin) Subcutaneous Solution Pen-injector 100 unit/mL (milliliters) - Inject 17 units subcutaneously at 8:00 A.M. and 8:00 P.M. for type 2 diabetes mellitus, dated 7/16/24 The September 2024 Medication Administration Record (MAR) indicated Registered Nurse (RN) 21 gave Resident 1 the 8:00 A.M. dose of insulin glargine on 9/23/24. On 10/9/24 at 2:41 P.M., the nursing schedule for 9/22/24 through 9/28/24 was reviewed. The schedule indicated there were no nurses working at the facility on 9/23/24 from 6:00 A.M. to 9:40 A.M. Registered Nurse (RN) 21 began their shift at 9:40 A.M. 3. On 10/10/24 at 3:27 P.M., Resident 17's clinical record was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 9/23/24, indicated Resident 17 had no cognitive impairment and received insulin. Physician orders included, but were not limited to: Lantus (insulin glargine - a long-acting insulin) Subcutaneous Solution 100 unit/mL (milliliters) - Inject 20 units subcutaneously at 8:00 A.M. for type 2 diabetes mellitus, dated 7/11/24 The September 2024 Medication Administration Record (MAR) indicated Registered Nurse (RN) 21 gave Resident 17 the 8:00 A.M. dose of insulin glargine on 9/23/24. On 10/9/24 at 2:41 P.M., the nursing schedule for 9/22/24 through 9/28/24 was reviewed. The schedule indicated there were no nurses working		but not limited to, respective scopes of practice and timely administration and documentation of insulin administration. 4. How the corrective action(s) will be monitored? DNS, or designee, will be responsible to complete medication observation pass audits at least 5 times a week for 1 month, then 3 times a week for f1 month, then 2 times a week for 4 months, at varied times, to ensure insulin is being administered timely and by qualified staff. Any identified concerns will be promptly addressed with the responsible individual(s). The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Completion Date: November 11, 2024	

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	at the facility on 9/23/24 from 6:00 A.M. to 9:40 A.M. Registered Nurse (RN) 21 began their shift at 9:40 A.M. 4. On 10/10/24 at 3:29 P.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 9/12/24, indicated Resident 11 had mild cognitive impairment and received insulin. Physician orders included, but were not limited to: Insulin Glargine (a long-acting insulin) Solution 100 unit/mL (milliliters) - Inject 16 units subcutaneously at 8:00 A.M. and 8:00 P.M. for diabetes for type 2 diabetes mellitus, dated 2/1/24 Admelog SoloStar (insulin lispro - a short-acting insulin) Subcutaneous Solution Pen-injector 100 unit/mL - Inject as per sliding scale: if 141 - 180 = 2 units; 181 - 240 = 4 units; 241 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; above 400 12 units subcutaneously with meals for type 2 diabetes mellitus, dated 9/13/24 The September 2024 Medication Administration Record (MAR) indicated Registered Nurse (RN) 21 gave Resident 11 the 8:00 A.M. dose of insulin glargine and insulin lispro on 9/23/24. On 10/9/24 at 2:41 P.M., the nursing schedule for 9/22/24 through 9/28/24 was reviewed. The schedule indicated there were no nurses working at the facility on 9/23/24 from 6:00 A.M. to 9:40 A.M. Registered Nurse (RN) 21 began their shift at 9:40 A.M. 5. On 10/10/24 at 3:33 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but			

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	were not limited to, type 2 diabetes mellitus. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 9/3/24, indicated Resident 8 had no cognitive impairment and received insulin. Physician orders included, but were not limited to: Insulin Glargine (a long-acting insulin) Solution 100 unit/mL - Inject 15 units subcutaneously at 8:00 A.M. for type 2 diabetes mellitus, dated 7/19/24 The September 2024 Medication Administration Record (MAR) indicated Registered Nurse (RN) 21 gave Resident 8 the 8:00 A.M. dose of insulin glargine on 9/23/24. On 10/9/24 at 2:41 P.M., the nursing schedule for 9/22/24 through 9/28/24 was reviewed. The schedule indicated there were no nurses working at the facility on 9/23/24 from 6:00 A.M. to 9:40 A.M. Registered Nurse (RN) 21 began their shift at 9:40 A.M. On 10/10/24 at 1:40 P.M., the Director of Nursing (DON) indicated she was at the facility on 9/23/24 a little before 6:00 A.M. but worked as a CNA (Certified Nurse Aide) that morning. She could not provide documentation that placed her in the facility on 9/23/24 from 6:00 A.M. to 9:40 A.M. She indicated that she could not remember if she gave insulin that morning, and the insulin was probably given to residents late after RN 21 arrived for her shift at 9:40 A.M. At that time, she indicated that QMA 2 did not give insulin and it was documented in error, but she was not sure who gave the insulin on 9/23/24 at 7:30 A.M. On 10/8/24 at 11:30 A.M., the Administrator			

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	provided a Medication Administration and General Guidelines policy, dated 2020, that indicated "Medications are administered within one hour of the scheduled time... Before or after meal orders are administered precisely as ordered... The resident's MAR is initialed by the person administering a medication...". On 10/10/24 at 4:06 A.M., the Regional Support provided a current Charting and Documentation policy, dated 8/2024, that indicated "Documentation in the medical record will be...accurate". On 10/10/24 at 4:06 P.M., the Regional Support provided a current Staffing, Sufficient and Competent Nursing policy, dated 8/2024, that indicated "Licensed nurses...are available 24 hours a day, seven (7) days a week to provide competent resident care services". On 10/10/24 at 4:06 P.M., the Regional Support provided a current undated Qualified Medication Aide Scope of Practice policy that indicated "The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all ... The following tasks shall not be included in the QMA scope of practice: Administer medication by the injection route, including the following...subcutaneous route". 3.1-35(g)(1)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on observation, interview, and record review, the facility failed to post accurate actual hours worked for licensed and unlicensed nursing	F 0732	This Plan of Correction is the center's credible allegation of compliance.	11/11/2024

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	staff directly responsible for resident care per shift daily for 3 of 4 days during the annual survey period. Finding includes: During an observation on 10/8/24 at 3:12 P.M., a posted nurse staffing data sheet, dated 10/8/24, was observed on the front desk inside the main entrance. The sheet included, but was not limited to, the following information: Census, total number of staff for each shift and total hours of each shift for Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nurse Aide (CNA). The sheet indicated that staff worked day shift, evening shift, and night shift, but did not indicate the actual hours of those shifts. The sheet indicated 1 CNA worked 4 hours during the evening shift, but did not specify the actual hours that the staff worked. On 10/10/24 at 10:30 A.M., the Director of Nursing (DON) provided a copy of posted nurse staffing sheets for dates 10/8/24, 10/9/24, and 10/10/24. Each of these dates did not reflect actual hours worked. On 10/10/24 at 11:00 A.M., the Administrator indicated the facility did not have an evening shift and was unable to tell the actual hours staff worked by looking at the posted nurse staffing sheet. On 10/10/24 at 4:06 P.M., the Regional Support provided a current Posting Direct Care Daily Staffing Numbers policy, dated 8/2024, that indicated "The information recorded on the form shall include...the actual time worked during that shift for each category and type of nursing staff".		Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were negatively affected by the cited practice. All revised Nursing Staffing Data Sheet was provided to DNS at the time of survey for future use. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents of the facility have the potential to be affected; therefore, this plan of correction applies to all residents currently residing in the facility. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?	

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			DNS and Nursing Scheduler have been re-educated relative to Posted Nursing Staffing Information, including but not limited to, ensuring that Posted Nursing Staffing sheets are accurate including hours worked for licensed and unlicensed nursing staff directly responsible for resident care. 4. How the corrective action(s) will be monitored? DNS, or designee, will audit the Posted Nursing Staffing sheets 5 days a week for 1 month, then 3 days per month for 5 months to ensure that Posted Nurse Staffing sheets are accurate including hours worked for licensed and unlicensed nursing staff directly responsible for resident care. Any identified concerns will promptly be addressed with the responsible individual(s). The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Completion Date: November 11, 2024	

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F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service Based on interview and record review, the facility failed to ensure social services were provided to meet a resident's mental and psychosocial needs for 1 of 1 residents reviewed for mood disturbances. (Resident 21) Finding includes: During an interview on 10/8/24 at 11:38 A.M., Resident 21 appeared to be anxious and indicated he had a history of PTSD (Post Traumatic Stress Disorder) but had not met with mental health services since admission. On 10/8/24 at 2:32 P.M., Resident 21's clinical record was reviewed. Resident 21 was admitted on 8/9/24. Diagnoses on admission included, but were not limited to, Post Traumatic Stress Disorder (PTSD) and Borderline Personality Disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/25/24, indicated Resident 21 was cognitively intact and was independent for eating, toileting, and transfers. A review of current orders indicated Resident 21 was not receiving medications related to mental health diagnoses. Current care plans included, but were not limited to: Risk for Ineffective Coping due to 31 years in maximum security prison, PTSD diagnosis and incidences witnessed while detained all those	F 0745	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #21 was referred to psychological services on 10/10/23 and is currently waiting to be seen. Several attempts have been made for the resident to be seen; however, resident frequently goes on LOAs and is not in the facility when psychological service providers are present. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken?	11/11/2024

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	years, Date Initiated: 8/15/24 Collaborate care with medical providers and psych services, Date Initiated: 8/15/24 On 8/8/24 a Preadmission Screening and Resident Review (PASRR) screening was completed for Resident 21 prior to admission. The screening indicated no mental health diagnosis was known or suspected. On 8/9/24 Resident 21 completed a form that indicated he would like to receive mental health services while in the facility. On 8/15/24 a form titled PHQ-9 Questionnaire (an assessment that measures the severity of depression), containing answers given by Resident 21, was completed by the Social Service Director (SSD). The total score indicated Resident 21 experienced mild depression. During an interview on 10/9/24 at 10:20 A.M., the SSD indicated the hospital completed the PASRR screening incorrectly prior to admission to the facility but the assessment should have been reviewed and resubmitted correctly on admission by the facility. The SSD indicated when a resident answered questions on the PHQ-9 Questionnaire that indicated depression, mental health services were offered, and indicated Resident 21 should have received mental health services but the behavioral health company that was contracted through the facility could not bill Resident 21's insurance and the facility would have to pay for the services. No other providers were contacted. On 10/11/24 at 8:30 A.M., the Regional Support provided a document titled Position Description Social Services Director that indicated "The Social Services Director provides medically-related social		All residents with psychological concerns/psychiatric diagnoses have the potential to be affected by the cited practice. An audit has been conducted to identify those residents; this plan of correction applies to all those identified. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? SSD has been re-educated relative to Provision of Medically Related Social Services, including but not limited to, ensuring social services are provided to meet resident's mental and psychosocial needs. 4. How the corrective action(s) will be monitored? Executive Director (ED) or designee, will audit the charts of all new admissions 3 times per week for 1 month, then 2 times per week for 1 month, then 1 time weekly for 4 months to ensure appropriate referrals have been sent, including necessary psychological services, with the same documented. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months. the QA Committee will identify any	

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	services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Essential position functions: Assesses each resident's psychosocial needs and develops a plan for providing care. Collaborates with other departments, physicians, consultants, community agencies, and institutions to improve the quality of services and resolve identified problems". 3.1-34(a)		trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Completion Date: November 11, 2024	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications for 1 of 5 residents reviewed for unnecessary medications. A resident's as needed antianxiety medication was ordered for greater than 14 days. (Resident 18) Finding includes: On 10/9/24 at 10:06 A.M., Resident 18's clinical record was reviewed. Diagnoses included, but were not limited to, generalized anxiety disorder. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 7/22/24, indicated Resident 18 had no cognitive impairment and received an antianxiety medication. Physician orders included, but were not limited to: diazepam (an antianxiety medication) 2 milligrams (mg) - Give 0.5 tablet by mouth every 8 hours as needed for anxiety, dated 8/28/24 with no end date. The Medication Administration Record (MAR)	F 0758	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #18's PRN anti-anxiety medication was discontinued on 10/10/24 with a routine order obtained from the physician.	11/11/2024

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	from 8/28/24 to 10/9/24 indicated Resident 18 received as needed (PRN) antianxiety medication on the following dates: 8/28/24 8/29/24 8/30/24 9/2/24 9/3/24 9/4/24 9/6/24 9/10/24 9/11/24 9/16/24 9/17/24 9/18/24 9/23/24 9/24/24 9/25/24 9/26/24 10/1/24 10/2/24 10/7/24 10/9/24 On 10/10/24 at 10:20 A.M., the Director of Nursing (DON) indicated that PRN antianxiety medications should have a stop date of 14 days. The medication needed to be reviewed by the physician every 14 days to evaluate for continuance. On 10/11/24 at 8:30 A.M., the Administrator provided a current Psychotropic Medication Use policy, dated 8/2024, that indicated "PRN orders for psychotropic medications are limited to 14 days". 3.1-48(a)(2)		2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? Any resident with a PRN order for psychotropic medication has the potential to be affected by the cited practice. An audit has been conducted to ensure any PRN psychotropic medications have review/stop dates no greater than 14 days post-order date, unless continued necessity was identified - with an extension ordered. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff and SSD have been re-educated relative to Free from Unnecessary Psychotropic Meds/PRN Use, including but not limited to ensuring a review date no more than 14 days after the initial order date is specified - unless an extension is ordered. 4. How the corrective action(s) will be monitored? DNS, or Designee, and IDT will review daily, on scheduled days of work, during clinical meeting, ongoing, new physician orders for psychotropic medications to ensure re-evaluation/stop dates	

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			are specified. Any identified concerns will be addressed with the responsible individual(s). The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Completion Date: November 11, 2024	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to ensure medications were labeled, opened-multi-dose containers were dated, and medication carts were free of loose pills for 1 of 2 medication carts observed. (100 hall med cart) Finding includes: On 10/9/24 at 7:40 A.M., the following were observed in the 100 hall med cart: an oblong maroon colored pill a small round white pill two dropper bottles of medication with no patient label two open bottles of multi-dose medications with no date written on them to indicate when they had been opened	F 0761	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the	11/11/2024

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	On 10/10/24 at 1:50 P.M., the Director of Nursing (DON) indicated that multi-dose medications such as Miralax, did not need to have the date opened written on them. A Medication Labeling and Storage policy, provided by the Administrator on 10/11/24 at 8:30 A.M., indicated "medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received... multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial". 3.1-25(j)		deficient practice? The loose pills, the unlabeled dropper bottles of medication, and the open bottles of undated multi-dose medications were removed from the 100-hall medication cart at the time of survey. The multi-dose medications were reordered from the pharmacy. NO residents were negativity affected by the cited practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents of the facility have orders for medications; therefore, this plan of correction applies to all residents currently residing in the facility. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses and QMAs have been re-educated relative to Label/Store Drugs and Biologicals, including but not limited to, ensuring loose pills are removed from the medication carts routinely, medications are correctly labeled with resident	

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			identifying information, and multi-dose medications are labeled with the open date. 4. How the corrective action(s) will be monitored? DNS, or designee, will be responsible daily, on scheduled days of work, for 1 month to audit 1 medication cart and 1 medication room, then 1 medication cart and 1 medication room 2 times weekly for 1 month, then 1 medication cart and 1 medication room 1 time weekly for 4 months to ensure there are no loose pills, medications are correctly labeled with resident identifying information, and all multi-dose medications are labeled with the open date. Any identified concerns will be promptly addressed with the responsible individual(s). The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Completion Date: November 11, 2024	

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F 0805 SS=D Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs Based on observation and record review, the facility failed to ensure food was correctly prepared for 2 of 2 residents who received puree altered diets. Finding includes: During an observation on 10/10/24 at 10:02 A.M., Dietary Cook 4 was preparing puree foods for resident's with altered dietary needs. The recipe #1028 titled Ham with Raisin Sauce Pureed Thick indicated the following measurements for 15 servings: Baked Ham with Raisin Sauce - 15 of three slices, 2 tablespoons sauce Apple Juice - 7.5 of four fluid ounces Food thickener - 3/4 cup 3 tablespoons Dietary Cook 4 gathered food and supplies for five (5) servings for each food. Dietary Cook 4 indicated she was unsure of the conversion from 15 servings to 5 servings. The Administrator wrote the conversions on the recipe and gave it to Dietary Cook 4. The handwritten conversions were written as follows: Five ham slices with raisin sauce 14 ounces of fluid for apple juice Thickener 1/4 cup and one tablespoon Dietary Cook 4 put the following food amounts in the puree machine:	F 0805	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Dietary Cook #4 was re-educated at the time of survey relative to proper preparation of pureed foods. NO residents were negatively affected by the cited practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken?	11/11/2024

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	15 slices of ham 1/2 cup (four fluid ounces) apple juice one tablespoon of food thickener Dietary Cook 4 emptied the contents of the puree food into a food canister, wrapped the top with plastic wrap, and transferred the canister to the temperature holding area. During an interview on 10/10/24 at 11:15 A.M., the Administrator indicated the puree conversions were incorrect. On 10/11/24 at 9:02 A.M., Regional Support provided a document titled Food Preparation and Service, revised 11/22, that indicated "Food and nutrition services employees prepare, distribute, and serve food in a manner that complies with safe food handling practices. Food preparation means the series of operational processes involved in preparing foods for serving such as:.. pureeing". 3.1-21(a)(3)		All residents who have mechanically altered diets, including pureed diets, have the potential to be affected. An audit has been conducted to identify those residents; this plan of correction applies to identified residents. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Dietary employees have been re-educated relative to Food in Form to Meet Individual Needs, including but not limited to, correct preparation of mechanically altered diets, including pureed diets. 4. How the corrective action(s) will be monitored? Dietary Manager, or designee, will be responsible to visually observe preparation of mechanically altered foods daily to ensure meals are prepared properly, on scheduled days of work, for 2 weeks, then 3 times weekly for 2 weeks, then 2 times weekly for 5 months. Any identified concerns will be promptly addressed with the responsible individual(s). The results of these audits will be reviewed in Quality Assurance	

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			Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Completion Date: November 11, 2024	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 2 of 3 residents reviewed for elopement and 1 of 2 residents reviewed for falls. Documentation required for a resident leave of absence (LOA) was not completed and neurological checks were not completed as ordered after a fall. (Resident 22, Resident 21, Resident 2) Findings include: 1. On 10/9/24 at 9:12 A.M., Resident 22's clinical record was reviewed. Diagnoses included, but were not limited to, schizophrenia and stimulant dependence. Resident 22 was admitted to the facility on 9/13/24. The most current Admission Minimum Data Set (MDS) Assessment, dated 9/20/24, indicated Resident 22 had no cognitive impairment and was independent in all Activities of Daily Living (ADLs).	F 0842	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1.) Resident #22 no longer resides at the facility; therefore, no further corrective action could be taken for this resident.	11/11/2024

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	A Letters of Temporary Guardianship document, dated 8/29/24, indicated Resident 22 was assigned a court-appointed guardian. An Admission Elopement Risk Assessment, dated 9/13/24, indicated Resident 22 was at low risk for elopement. On 10/9/24 at 11:30 A.M., an elopement binder was observed on the 300 hall nurses station desk. The binder indicated Resident 22 was at risk for elopement. The binder included, but was not limited to, Resident 22's picture, name, date of birth, room number, physician name, and emergency contact name. The emergency contact listed was the court-appointed guardian. A physician order, dated 10/1/24, indicated that the resident had a state guardian and was not permitted to go outside and smoke or leave the facility unless approved by the guardian. A Release Of Responsibility For Leave Of Absence (LOA) document indicated the resident signed herself out of the facility on the following dates: 9/17/24 at 12:20 P.M. 9/18/24 at 11:33 A.M. 9/18/24 at 1:45 P.M. 9/18/24 at (illegible time) 9/18/24 at 5:10 P.M. 9/18/24 at 7:00 P.M. 9/19/24 at 3:50 P.M. 9/19/24 at 6:10 P.M. 9/22/24 at (illegible time) 10/3/24 at 1:30 P.M. A Nursing Progress note, dated 10/7/24 at 6:26 P.M., indicated the resident left the facility independently and returned "weak".		2.) Resident#21's physician order for LOA was obtained on 10/09/24, "Resident may go on therapeutic leave with medications." Resident #21 does frequently go on LOA, if resident is going to be out of the facility when medications are due, resident will request the medications be taken with him. Typically, the resident is not out of the facility at medication administration times, thus, medications are not required to be sent with the resident, and no documentation of medications sent is necessary. 3.) Resident #2 did have missing entries on the neurological checks referenced on the 2567, however, most of the checks were completed with no neurologic changes identified. Resident # 2 did not have any negative outcomes as a result of the cited practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? Residents with orders for LOA with supervision and/or with medications have the potential to be affected by the cited practice. An audit of physician orders has been conducted to identify those residents who require supervised LOAs, or who require medications	

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	The clinical record lacked documentation indicating who the resident left with, expected time of return, instructions provided, and a list of medications sent. On 10/9/24 at 2:50 P.M., Social Services Director (SSD) indicated the resident was to check in with the SSD when she left and came back. She indicated the resident had been doing that, but the SSD was not documenting those occurrences. On 10/10/24 at 1:40 P.M., the Director of Nursing (DON) indicated that documentation regarding the times Resident 22 went LOA could not be found. 2. On 10/8/24 at 2:32 P.M., Resident 21's clinical record was reviewed. Resident 21 was admitted on 8/9/24. Diagnoses on admission included, but were not limited to, osteomyelitis, Post Traumatic Stress Disorder (PTSD), and Borderline Personality Disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/25/24, indicated Resident 21 was cognitively intact and was independent for eating, toileting, and transfers. On 10/9/24 at 11:55 A.M., the Leave of Absence (LOA) binder was reviewed. Resident 21 signed himself out on the following days and times: 10/6 12:50 10/6 2:32 10/7 1:05 10/7 4:05 10/8 9:51 10/8 2:10 10/9 8:43 The leave of absence form and clinical record, including progress notes and assessments, lacked		to be sent when on LOA. The care plan of those residents identified will be reviewed and revised, as necessary. Residents who have sustained falls have the potential to be affected by the cited practice. An audit has been conducted to identify residents who have sustained falls in the last 60 days, those residents who have had falls requiring neurologic checks to be completed (e.g. unwitnessed, or resident hit their head) have had a baseline neurologic check (Envive Neurologic Check User Defined Assessment - UDA) completed to ensure no negative outcome. NO concerns were identified. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nursing staff have been re-educated relative to Resident Records - Identifiable Information, including but not limited to, ensuring that accurate and complete documentation is present for residents who leave the facility on LOAs, and accurate and complete documentation of neurological checks, when necessary. 4. How the corrective action(s) will be monitored?	

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	documentation indicating if medications were sent with Resident 21 during each leave of absence, date and time the resident arrived back to the facility, and signature of facility representative for each leave of absence. On 10/9/24 at 3:55 P.M., the facility elopement binder was reviewed. Resident 21 was observed in the binder along with an identifying photo. The clinical record lacked an order related to approval of physician for independent leave of absence. 3. On 10/9/24 at 12:22 P.M., Resident 2's clinical record was reviewed. Diagnoses included, but were not limited to, repeated falls, hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side, and symptoms and signs involving cognitive functions and awareness The current Quarterly Minimum Data Set (MDS) Assessment, dated 9/13/24, indicated Resident 2 was mildly cognitively impaired, required partial assistance of staff (staff does less than half) with hygiene and dressing, and had no falls since the prior assessment. Physician's orders included, but were not limited to: Bilateral side rails to promote bed mobility every shift, dated 4/8/24. Activity Level: WBAT (Weight Bearing as Tolerated), dated 4/8/24. The current falls care plan indicated that Resident 2 was at risk for falls/injury due to impaired mobility and history of falls, dated 4/8/24. Interventions included, but were not limited to: Encourage staff to assist with transfer and ADL (Activities of Daily Living)		DNS, SSD, or designee, will review LOA logs 5 days a week for 1 month and 3 days a week for 5 months to identify any LOAs that require resident representative and/or physician notification, and to ensure notifications have been made, and that documentation relative to LOAs is complete and accurate. Any identified concerns will promptly be addressed with the responsible individual(s). DNS, or designee, will complete an audit of the neurological checks of all residents requiring them, daily, on scheduled days of work for 1 month to validate that all neurological checks have been completed, and documented. Thereafter, DNS, or designee, will complete audits of the neurological checks of residents requiring them 3 times per week for 2 months and then 2 times per week for 3 months. Any identified concerns will be promptly addressed with the responsible individual(s). The results of the audits will be reviewed by Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the	

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	Footwear to prevent slipping Anticipate and meet the resident's needs. On 10/9/24 at 2:15 P.M., the Administrator provided copies of the neurological check list for Resident 2 as follows: Fall 1 On 9/23/24 at 10:00 A.M., the fourth 4-hour neuro check was partially completed. On 9/23/23 at 2:00 P.M., the fifth 4-hour neuro check was left blank. On 9/23/23 at 4:00 P.M., the sixth 4-hour neuro check was left blank. Fall 2 On 7/19/24 at 1:15 P.M., the second 15-minute check was left blank. On 7/19/24 at 1:30 P.M., the third 15-minute check was left blank. On 10/10/24 at 9:43 A.M., the Director of Nursing (DON) indicated that when there was an unwitnessed fall, neuro checks were completed and should be filled out completely. If there was some reason that the checks could not be done at the scheduled time, it should be completed late. On 10/9/24 at 11:55 A.M., the DON provided a current Guidelines for LOA policy, dated 6/2023, that indicated "Nursing documentation should include: the date and time the resident left, who they left with, expected time of return, instructions provided, and medications sent (type and number of doses)". On 10/10/24 at 4:06 P.M., the Regional Support provided a current Charting and Documentation policy, dated 8/2024, that indicated "Documentation in the medical record will be objective (not opinionated or speculative),		plan of correction as indicated. 5. Completion Date: November 11, 2024	

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	complete, and accurate". On 10/10/24 at 4:06 P.M., the Administrator provided a current policy Neurological Assessment (Routine), revised on 8/2024, that indicated "...the following information should be recorded in the resident's medical record...all assessment data obtained during the procedure...". 3.1-50(a)(1) 3.1-50(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure a resident with a PICC (peripheral injection central catheter) and multiple wounds was provided enhanced barrier precautions (EBP) for 1 of 1 resident reviewed for infection control. (Resident 225) Finding includes: On 10/9/24 at 11:40 A.M., Registered Nurse (RN) 9 was observed preparing vancomycin 750 milligrams (mg) / 150 milliliters (mL) to administer to Resident 225. A sign on the door indicated the resident was on enhanced barrier precautions (EBP). RN 9 did not donn a gown prior to caring for the resident. RN 9 flushed the first lumen on Resident 225's PICC line with 10 mL of saline and then flushed the second lumen on the PICC line with 8 mL of saline. RN 9 hooked the vancomycin to the PICC line and set the medication to run at 150 drops per minute. At that time, a wound vac was observed on the resident's coccyx. On 10/9/24 at 1:53 P.M., Resident 225's clinical	F 0880	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? RN#9 was re-educated at the time of survey related to Enhanced Barrier Precautions (EBP).	11/11/2024

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	record was reviewed. Diagnoses included, but were not limited to, osteomyelitis (infection in the bone). An admission skilled nursing note, dated 10/6/24, indicated that Resident 225 had a power injection catheter in right chest and wounds on the left gluteal fold, right gluteal fold, coccyx, and left toe. Initial wound measurements were: Left gluteal fold 6 cm (centimeters) x 2 cm x 0.2 cm Right gluteal fold 3 cm x 1.5 cm x 0.2 cm Coccyx wound vac in place Left toe 1.2 cm x 0.1 cm x 0.1 cm. The clinical record lacked orders for enhanced barrier precautions or transmission-based precautions related to Resident 225's wound and PICC line. Current care plans for Resident 225 included, but were not limited to: I have a venous access device specify: picc, midline, Peripheral IV related to antibiotics, date initiated 10/5/2024. If Resident has swelling or increased pain during infusion, stop IV and notify provider, date initiated 10/5/2024. IV assessment as indicated, date initiated 10/5/2024. Labs as ordered, date Initiated 10/5/2024. Notify provider for signs and symptoms of infection, extravasation, infiltration, increased pain, date initiated 10/5/2024. Treatments as ordered, date initiated 10/5/2024. I am receiving IV (intravenous) medications for: osteomyelitis and cellulitis (skin infection), date initiated 10/5/2024. On 10/10/24 at 12:41 P.M., the Director of Nursing indicated staff should wear personal protective		Necessary physician orders for Resident # 225 pertaining to the PICC line and precautions were obtained at the time of the survey. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? Residents who meet the criteria for placement in EBP have the potential to be affected by the cited practice. An audit has been conducted to identify these residents with physician orders obtained and care plans updated, as necessary. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All staff, excluding Dietary, have been re-educated relative to Infection Control and Prevention including but not limited to, criteria for placing a resident EBP, and ensuring all necessary components are in place such as physician orders and care plans, etc. Licensed nursed have received re-education relative to Infection Control and Prevention including but not limited to, ensuring all necessary physician orders are	

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	equipment when providing care to resident. An Enhanced Barrier Precautions policy, provided by Regional Support on 10/11/24 at 10:01 A.M., indicated "enhanced barrier precautions are used as an infection prevention and control intervention to reduce the spread of multi drug resistance organisms to residents. EBPs employ targeted gown and glove used during high contact resident care activities.... examples of high-contact resident care activities are device care or use (central line)". 3.1-18(b)		present (e.g., wound care, IV care, infection control, etc.) 4. How the corrective action(s) will be monitored? The IP nurse/DNS/designee will complete random visual rounds daily, on scheduled days of work, for 1 month, then 3 times per week for 1 month, then 2 times per week for 4 months to ensure staff are practicing appropriate Infection Control Practices, including but not limited to, identified residents are in EBP with all the necessary components in place. Any identified concerns will be promptly addressed with the responsible individual(s). DNS, or designee, will be responsible for auditing the charts of all residents with PICC lines or other intravenous lines daily, on scheduled days of work, for 1 month to ensure all necessary physician orders are present. Thereafter, the DNS, or designee, will be responsible for auditing the charts of all residents with PICC lines or other intravenous lines 3 times per week for 1 month, then 2 times per week for 4 months to ensure all necessary physician orders are present. Any identified concerns will be promptly addressed with the responsible individual(s).	

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Completion Date: November 11,2024	
F 0882 SS=D Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role Based on interview and record review, the facility failed to ensure designation of a certified Infection Preventionist (IP). The IP did not currently dedicate at least part time to the role of IP for 1 of 1 staff members reviewed for IP. Findings include: On 10/8/24 at 12:10 P.M., the Director of Nursing (DON) indicated she was currently responsible for the infection prevention and control program in the facility. She indicated she worked full time as the DON, and was able to dedicate about 8 hours per week on the infection control program. On 10/9/24 at 1:49 P.M., the DON's employee file was reviewed. The DON had an IP certification dated 11/14/21. On 10/11/24 at 8:50 A.M. the Administrator provided a current undated "Job Description:	F 0882	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were negatively	11/11/2024

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	Infection Preventionist Nurse" job description. The job description indicated "... the IP provides assistance to the Director of Nursing when needed". On 10/9/24 at 11:30 A.M., the Administrator provided a current Infection Prevention and Control Program (IPCP), dated 8/2022, that indicated "The community shall designate a member of the clinical team to monitor the campus IPCP program to perform surveillance to identify, investigate, control, and prevent the spread of infection and reporting for the IPCP".		affected by the cited practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents of the facility have the potential to be affected; therefore, this plan of correction applies to all residents currently residing in the facility. 3. What measures will be put into place and what systemic changes willbe made to ensure that the deficient practice does not recur? ED and DNS have been re-educated relative to Infection Preventionist (IP) Qualifications/Role, including but not limited to, ensuring the designation of a certified Infection Preventionist. 4. How the corrective action(s) will be monitored? DNS, or designee, will be responsible daily, on scheduled days of work for 1 month, then 2 times per week for 5 months, to ensure that an IP is in place and dedicating at least part-time to the role of IP. Any identified concerns will be promptly addressed with the responsible individual(s).	

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			The results of these audits will be reviewed in Quality Assurance Meeting Monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Completion date: November 11,2024	
F 9999 Bldg. 00	#1. 3.1-13 ADMINISTRATION AND MANAGEMENT (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents This state rule was not met as evidenced by: Based on interview and record review, the facility failed to report a resident was found with an illegal	F 9999	The Plan of Corrective is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? #1Administration and	11/11/2024

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	substance to the Indiana Department of Health (IDOH) for 2 of 3 residents reviewed for unnecessary medication. (Resident 22, Resident 18) Findings include: 1. On 10/9/24 at 9:12 A.M., Resident 22's clinical record was reviewed. The most current Admission Minimum Data Set (MDS) Assessment, dated 9/20/24, indicated the resident had no cognitive impairment. A Social Services progress note, dated 9/27/24 at 11:39 A.M., indicated a Certified Nursing Aide (CNA) notified the Social Service Director (SSD) and Director of Nursing (DON) that Resident 22 and another resident were seen crushing a white substance in a baggy. The white substance was found hidden in the resident's deodorant container. Law enforcement was called. An officer tested the substance upon arrival and it tested positive for methamphetamine (meth). Resident 22 admitted to using the drug but would not say how long she had the drugs in her possession or where she got them. 2. On 10/9/24 at 10:06 A.M., Resident 18's clinical record was reviewed. The most current Quarterly MDS Assessment, dated 7/22/24, indicated Resident 18 had no cognitive impairment. A Social Service progress note, dated 9/27/24 at 4:44 P.M., indicated the SSD and DON asked Resident 18 if another resident was in her room with a baggy containing something. Resident 18 indicated it was meth and Resident 22 ingested it, but she did not take any. A review of Facility Reported Incidents for		Management 1.) Resident #22 no longer residents at the facility; therefore, no further corrective action could be taken for this resident. 2.) Resident #18 did not ingest any of the substance, therefore, there was nothing to report, and there was no negative effect to this resident. #2Personnel 1.) All employee files have been audited with references obtained and placed in the files, as necessary. #3 Personnel 1., 2., &3). All employee files have been audited with job descriptions, orientation to the facility, job specific orientations, and orientation to resident rights obtained and placed in the files, as necessary. #4 Personnel 1.) All employee files have been audited with physical examinations and TB screens/annual TB risk assessments obtained and placed in files, as necessary. #5 Personnel 1.) All employee files have been audited with dementia-specific training conducted and	

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	September lacked a report of the police being called to the facility for residents with methamphetamine. On 10/10/24 at 9:04 A.M., the DON indicated she was told by a corporate employee that finding illegal substances in the facility and calling law enforcement was not a reportable offense. She indicated she would not speak to whether or not finding meth in the building was an unusual occurrence or not. The facility did not do an investigation into the incident, and neither resident was drug tested because Resident 22 admitted to using the drug and Resident 18 was headed to dialysis and it would be flushed out anyway. On 10/10/24 at 4:06 P.M., the Regional Support provided a current Unusual Occurrence Reporting policy, dated 8/2024, that indicated "Our facility will report the following events to appropriate agencies: ...other occurrences that interfere with facility operations and affect the welfare, safety, or health of residents, employees or visitors. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations". #2. 3.1-14 PERSONNEL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.		documentation of the same placed in the files, as necessary. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents of the facility have the potential to be affected; therefore, this plan of correction applies to all residents currently residing in the facility. All incidents that have occurred within the last 60 days will be reviewed and if any incidents meet the guidelines for incident reporting and have not been reported to IDOH, they will be reported. 3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? ED, DNS, and all necessary facility staff have been re-educated relative to Administration and Management, and Personnel requirements, including but not limited to, Indiana Reportable Unusual Occurrence Guidelines and Reporting; pre-employment requirements: references, physical examinations and TB screening; and education requirements (e.g. orientation to the facility,	

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	This state rule was not met as evidenced by: Based on interview and record review, the facility failed to screen prospective employees by checking employee references for 3 of 6 staff employed less than one year reviewed. (DON, Dietary Manager, MDS Coordinator) Finding includes: On 10/9/24 at 1:49 P.M., employee files were reviewed. Employee files for the Director of Nursing (DON), Dietary Manager, and Minimum Data Set (MDS) Coordinator lacked documentation of reference checks. On 10/11/24 at 9:08 A.M., the Regional Support indicated reference check documentation for the DON, Dietary Manager, and MDS Coordinator was unable to be found. On 10/11/24 at 9:38 A.M., the Regional Support provided a HR-101: Pre-Employment Reference Checks policy, dated 5/4/2024, that indicated "Former employer references must be obtained on all applicants being considered for employment. At least two (2) of the most recent employers must verify dates of employment, position held, and salary or hourly wage rate, if provided. Whenever possible, the actual job duties and performances should also be verified. When there is no prior employment, attempts should be made to obtain references from schools, churches, or personal associations. The Human Resources designee will conduct employer references". #3. 3.1-14 PERSONNEL (q) Each facility shall maintain current and		job-specific orientation, and dementia-specific training. 4. How the corrective action(s) will be monitored? The ED/Designee will review all occurrences with the IDT, daily, on scheduled days of work, ongoing, to determine if considered an unusual occurrence and will submit reportable unusual occurrences via the Gateway, when necessary. The ED/Designee will perform an audit of incidents that occur in the facility to ensure that incidents are reported to the IDOH in accordance with facility policy and the Indiana Long-Term Care Abuse and Incident Reporting Policy. Audits will be performed weekly for 1 month, then bi-weekly for 1 month, then monthly x 4 months. ED, or designee, will conduct an audit of at least 5 employee files weekly for 2 months, and then 5 employee files bi-weekly for 4 months to ensure all required pre-employment requirements and all required education/orientation is completed and placed in the files. Any identified concerns will be promptly addressed with the responsible individual(s).	

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	accurate personnel records for all employees. The personnel records for all employees shall include the following: (6) Position in the facility and job description. (7) Documentation of orientation to the facility and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to maintain personnel records with documentation of job description, general orientation, job specific orientation, and orientation to residents' rights for 6 of 10 employee records reviewed. (LPN 15, RN 7, DON, Dietary Manager, MDS Coordinator, QMA 2) Findings include: 1. On 10/9/24 at 1:49 P.M., employee files were reviewed. The employee file for Qualified Medication Aide (QMA) 2 lacked a job description. On 10/11/24 at 9:08 A.M., the Regional Support indicated a job description could not be found in QMA 2's employee file. On 10/11/24 at 9:46 A.M., the Regional Support indicated it was the facility's policy for a job description to be kept in an employee's file. 2. On 10/9/24 at 1:49 P.M., employee files were reviewed. Employee files for Registered Nurse (RN) 7, the Director of Nursing (DON), Dietary Manager, and Minimum Data Set (MDS) Coordinator lacked documentation of orientation to the facility and job specific orientation.		The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Completion Date: November 11, 2024	

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	On 10/11/24 at 9:08 A.M., the Regional Support indicated general and job specific orientation could not be found for RN 7, and job specific orientation could not be found for the DON, Dietary Manager, and MDS Coordinator. 3. On 10/9/24 at 1:49 P.M., employee files were reviewed. The employee file for Licensed Practical Nurse (LPN) 15 lacked documentation of orientation to residents' rights. On 10/11/24 at 9:08 A.M., the Regional Support indicated orientation to residents' rights could not be found for LPN 15. On 10/10/24 at 4:06 P.M., the Regional Support provided a current Orientation Program for Newly Hired Employees, Transfers, Volunteers, dated 8/2024, that indicated "Our orientation program is an in-depth review of our facility's policies and procedures. A checklist is used to record materials reviewed. A written record is maintained of each participant's orientation program. Orientation records include the date reviewed, participant's initials, subject matter reviewed, and other information deemed necessary or appropriate. Records of orientation are filed in the personnel file upon completion of the orientation program". On 10/11/24 at 8:30 A.M., the Administrator provided a current In-Service Training policy, dated 8/2024, that indicated "Required training topics include the following: ...resident rights and responsibilities". #4. 3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month			

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	prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure employees had a physical exam prior to employment, screen employees for tuberculosis (TB) at the time of employment, and perform a TB risk assessment annually for 4 of 6 staff employed less than one year reviewed and 4 of 4 staff employed greater than one year reviewed. (DON, QMA 2, Dietary Manager, RN 7, LPN 16, Dietary Cook 4, LPN 15, LPN 14) Findings includes:			

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	1. On 10/9/24 at 1:49 P.M., employee files were reviewed. Employee files for the Director of Nursing (DON) and Qualified Medication Aide (QMA) 2 lacked documentation that a physical exam had been performed within one month prior to employment. On 10/11/24 at 9:08 A.M., the Regional Support indicated he could not find documentation that a physical exam had been performed prior to employment for the DON and QMA 2. On 10/11/24 at 9:46 A.M., the Regional Support indicated that it was the facility's policy for staff to have a physical exam before hire. 2. On 10/9/24 at 1:49 P.M., employee files were reviewed. Employee files for the Director of Nursing (DON), Dietary Manager, and Registered Nurse (RN) 7 lacked a TB screen at the time of or one month prior to employment. Employee files for Licensed Practical Nurse (LPN) 16, Dietary Cook 4, LPN 15, and LPN 14 lacked a TB risk assessment dated in the last 12 months. On 10/11/24 at 9:08 A.M., the Regional Support indicated he could not find a TB screen dated at the time of or one month prior to employment for the DON, Dietary Manager, and RN 7. At that time, he indicated he could not find TB risk assessments dated in the last 12 months for LPN 16, Dietary Cook 4, LPN 15, and LPN 14. On 10/10/24 at 4:06 P.M., the Regional Support provided a Tuberculosis, Employee Screening For policy, dated 8/2024, that indicated "All employees are screened for latent tuberculosis infection (LTBI) and active tuberculosis (TB) disease, using tuberculin skin test (TST) or interferon gamma release assay (IGRA) and			

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	symptom screening prior to beginning employment ... The decision to perform serial (e.g. annual) testing after baseline is based on individual risk factors of exposure both at work and outside of work". #5. 3.1-14 PERSONNEL (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to provide documentation of staff completing a minimum of six hours of dementia-specific training within six months of initial employment for 2 of 6 staff employed less than one year reviewed and three hours of dementia-specific training annually for 4 of 4 staff employed greater than 1 year reviewed. (LPN 16, Dietary Cook 4, LPN 15, QMA 2, RN 9, LPN 14) Finding includes: On 10/9/24 at 1:49 P.M., employee files were reviewed. Employee files for Licensed Practical Nurse (LPN) 16, Dietary Cook 4, LPN 15, Qualified Medication Aide (QMA) 2, Registered Nurse (RN) 9, and LPN 14 lacked documentation of dementia-specific training.			

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	LPN 16 started employment with the facility on 3/26/14. Dietary Cook 4 started employment with the facility on 9/19/12. LPN 15 started employment with the facility on 9/18/23. QMA 2 started employment with the facility on 4/9/24. RN 9 started employment with the facility on 10/24/23. LPN 14 started employment with the facility on 6/15/20. On 10/9/24 at 2:55 P.M., the Regional Support provided a Course Completion History for all staff. At that time, he indicated that they were aware staff were behind on completing inservices. LPN 16 lacked 2 dementia inservice hours. Dietary Cook 4 lacked 3 dementia inservice hours. LPN 15 lacked 1 dementia inservice hour. QMA 2 lacked 6 dementia inservice hours. RN 9 lacked 6 dementia inservice hours. LPN 14 lacked 3 dementia inservice hours. On 10/11/24 at 8:30 A.M., the Administrator provided a current In-Service Training, All Staff policy, revised 8/2024, that indicated "Required training topics include the following...dementia management and resident abuse prevention".			