STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00449555, IN00451140, and IN00452206. Complaint IN00449555 - No deficiencies related to the allegations are cited. Complaint IN00451140 - Federal/State deficiencies related to the allegations are cited at F550. Complaint IN00452206 - Federal/State deficiencies related to the allegations are cited at F880. Survey dates: February 6, 7, 8, 10, 11, 12, 13, and 14, 2025. Facility number: 000032 Provider number: 155077 AIM number: 100273330 Census Bed Type: SNF/NF: 102 Total: 102 Census Payor Type: Medicare: 5 Medicaid: 92 Other: 5 Total: 102 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 27, 2025.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandon Levi Back	VP of Clinical Services	03/19/2025

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

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F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, interview, and record review, the facility failed to ensure a resident had the right to privacy during incontinent care for 1 of 4 residents reviewed for dignity (Resident B). Findings include: On 2/7/25 at 10:30 a.m., Resident B was observed from the hallway, through her open door, in bed on her left side, faced away from the door, and her privacy curtain was not closed. Registered Nurse (RN) 6 stood at the right side of her bed, and Certified Nursing Adie (CNA) 22 was on the left side of her bed. CNA 22 was observed as she removed a brief from under the resident, rolled it up, and placed it in a trash bag. RN 6 stepped toward the head of the resident's bed, so that her bare bottom and several wounds of varying conditions were visible from the hallway. On 2/7/25 at 10:35 a.m., an unidentified male resident ambulated past Resident B's open door. On 2/7/25 at 10:37 a.m., a second unidentified male resident ambulated past Resident B's open door. On 2/7/25 at 10:39 a.m., an unidentified Houskeeper (HK) stepped into the open door frame and asked if she could clean the room. RN 6 indicated, "patient care," and the HK went to the next room. During an interview on 2/7/25 at 10:45 a.m., after RN 6 exited the room, he indicated the door should have been closed, but he was in the middle of providing wound care treatment when one of the aides left to get a hoyer lift and must have	F 0550	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted between February 6-14, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of March 24, 2025. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance. p paraid="1150180189" paraeid="{6e05eed9-c3ae-47bd-a0f0-1de344c90b90}{62}" >F550 – Resident Rights/Exercise of Rights "Facility failed to ensure a resident had the right to privacy during incontinent care for 1 of 4 residents reviewed for dignity	03/24/2025

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	forgot to close the door. During an interview on 2/7/25 at 10:52 a.m., Resident B indicated staff leaves the doors open a lot of the time and it bothered her that another resident might have seen her bottom because she considered herself to be a modest religious person. On 2/13/25 at 1:35 p.m., Resident B's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, spina-bifida (a birth defect of the spinal cord), borderline intellectual functioning, and anxiety. A comprehensive care plan, dated 2/22/22, indicated Resident B had a diagnosis of borderline intellectual functioning and an intervention for this plan of care included, but was not limited to, "treat me with dignity and respect." On 2/14/25 at 9:30 a.m., the Vice President of Clinical Services (VPCS) provided a copy of current facility policy titled, "Dignity," revised 8/2024. The policy indicated, "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem ... residents are treated with dignity and respect at all times ... staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures ...." This deficiency relates to Complaint IN00451140. 3.1-3(a) 3.1-3(p)(4)		(Resident B)". 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B was affected by the alleged deficient practice. Resident B immediately had alleged deficient practice corrected by providing privacy during remaining care. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - Residents have the potential to be affected by the alleged deficient practice. Current in-house residents were audited on 3/10/25 by the DON for privacy concerns. None noted during this time. No further actions are required. 3: What measures will be put into place or what systemic changes will be made to ensure that the	

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			deficient practice does not recur? DON and ADON were educated with concentration on, but not limited to, resident dignity and resident rights by clinical support consultant. - Education and training provided to clinical staff on 3/13/25 by the DON and ADON Education provided: Envive Dignity Policy/Residents Rights p paraid="2019580297" paraeid="{6e05eed9-c3ae-47bd-a0f0-1de344c90b90}{246}" >4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DON/ADON/designee will complete daily monitoring through random audits to ensure that residents with dignity concerns and/or concerns or grievances related to dignity will be added to the grievance list for proper procedure 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6	

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			months. DON/ADON/designee will be responsible for the grievance log and monitoring compliance of the for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. ¿ The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. 5. Date of completion: 03/24/2025	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on interview and record review, the facility failed to ensure a resident's advance directive wishes were updated in her medical record for 1 of 3 residents reviewed for advance directive (Resident 53). Findings include: On 2/7/25 at 11:13 a.m., Resident 53 medical record	F 0578	F578 – Request/Refuse/Discontinue Treatment; Formulate Advanced Directive p="" paraid="657527696" paraeid="{5daeffd4-dc80-49e1-88fb-8469647be2a5}{89}">“Facility failed to ensure a resident's advance directive wishes were updated in her medical record for 1	03/24/2025

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	was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to dementia, schizoaffective disorder and peripheral vascular disease. An original Physician Scope of Treatment (POST) form, dated 10/2/23, indicated the resident wished to have a full code advance directive status. An updated POST form, dated 7/20/24, indicated Resident 53's wishes to change her advanced directive status to Do Not Resuscitate. Resident 53's physician's orders included but were not limited to an active order for a full code status, and not been revised to reflect her most recent POST orders. Resident 53's comprehensive care plans were reviewed and included but were not limited to a care plan, dated 10/4/23, which indicated she wished to be a full code. The care plan lacked revision to update her advanced directive wishes after her POST form was completed on 7/20/24. During an interview on 2/14/25 at 1:10 p.m., the Social Service Director, (SSD) reviewed Resident 53's two post forms, care plans and physician order. She indicated, it appeared that the physician order and care plan had not been updated as they should have been after the POST form was changed. On 2/14/25 at 1:32 p.m., the Vice President of Clinical Servies (VPCS) provided a copy of current facility policy titled, "Advance Directive," revised 2/2024. The policy indicated, " ...Advance directives are honored in accordance with state law and facility policy ... the director of nursing services (DNS) or designee notifies the attending		of 3 residents reviewed for advance directive (Resident 53)". 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 53 was affected by the alleged deficient practice. Resident 53 immediately had alleged deficient practice corrected by updating resident wishes related to advanced directive correctly updated in her medical record. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - Residents have the potential to be affected by the alleged deficient practice. Current in-house residents were audited on 3/12/25 by the DON for correctly documented advanced directives. Advanced directives were accurately documented in medical records. No further actions are required. p="" paraid="347011412" paraeid="{5daeffd4-dc80-49e1-88fb-8469647be2a5}{169}">3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur The DON and ADON were educated with concentration on, but not limited to, resident rights and advanced directives by clinical support . - Education and training	

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	physician of advance directives (or changes in advance directives) to that appropriate orders can be documented in the resident medical record and plan of care ...." 3.1-4(f)(7)		provided to licensed clinical staff on 3/13/25 by DON and ADON. Education provided: Envive Advanced Directives Policy 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DON/designee will complete daily monitoring to ensure that any resident with advanced directive changes, including new admissions, will be reviewed in clinical care meeting the following weekday for accuracy 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. DON/designee will be responsible for the advanced directive accuracy and monitoring compliance of them for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. ¿ The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. 5. Date of completion: 03/24/2025	
F 0641 SS=E Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility	F 0641	p paraid="312555891"	03/24/2025

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	failed to code Minimum Data Set (MDS) correctly for residents who required a level II according to Pre-admission screening and resident review (PASRR) for 4 of 5 residents reviewed for MDS accuracy (Residents 52, 49, 9, and 14). Findings include: 1. On 2/11/25 at 10:58 a.m., a record review was completed for Resident 52. He had the following diagnoses which included but were not limited to schizophrenia, muscle weakness, and hyperlipidemia (high cholesterol). Resident 52 had a level II PASRR dated 8/8/23. His Minimum Data Set (MDS) assessment, dated 4/4/24, indicated he did not require a level II PASRR. Resident 52 had a care plan, dated 7/26/23, indicated he required a level II PASRR. 2. On 2/11/24 at 11:04 a.m., a record review was completed for Resident 49. He had the following diagnoses which included but were not limited to schizophrenia, bipolar disorder, and arthritis. Resident 49 had a level II PASRR, dated 8/11/22. His MDS, dated 9/4/24, indicated he did not require level II PASRR. Resident 49 had a care plan, dated 7/26/23, that indicated he required level II PASRR. 3. On 2/11/24 at 11:01 a.m., a record review was completed for Resident 9. He had the following diagnoses which included but were not limited to hyperlipidemia, delusional disorder, psychotic disorder, generalized anxiety, and major depressive disorder.		paraeid="{d7c0a458-319d-410c-87 d6-5e8a71acadff}{58}" >F641 – Accuracy of Assessments “Facility failed to code Minimum Data Set (MDS) correctly for residents who required a level II according to Pre-admission screening and resident review (PASRR) for 4 of 5 residents reviewed for MDS accuracy (Residents 52, 49, 9, and 14).” 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents 52, 49, 9, and 14 were affected by the alleged deficient practice. Residents 52, 49, 9 and 14 immediately had alleged deficient practice corrected by completing accurate level II assessments. p paraid="1616222973" paraeid="{d7c0a458-319d-410c-87 d6-5e8a71acadff}{92}" > 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	

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	Resident 9 had a level II PASRR, dated 9/12/23. His MDS, dated 1/2/25, indicated he did not require level II. Resident 9 had a care plan, dated 12/11/23, indicating he required a level II PASRR. On 2/11/25 at 11:07 a.m., a record review was completed for Resident 14. He had the following diagnoses which included but were not limited to mood disorder with major depressive-like episode, anxiety disorder, adjustment disorder, psychotic symptoms, and asthma. Resident 14 had a level II PASRR dated 3/7/24. His MDS, dated 7/10/24, indicated he did not require a level II. Resident 14 had a care plan, dated 4/5/24, that indicated he required a level II PASRR. On 2/14/25 at 11:00 a.m., during an interview, the MDS Coordinator indicated she was new to the facility and could not explain why the level IIs were not coded accurately. A policy titled, "Resident Assessments" dated 8/24 was provided by the Vice President of Clinical Services (VPCS). It indicated, " ...Information in the MDS assessments will consistently reflect information in the progress notes, plan of care, and resident observations/interviews ...."		action will be taken. - Residents have the potential to be affected by the alleged deficient practice. Current in-house residents were audited on 3/10/25 by the MDS for correctly documented level II assessments. No further actions are required. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur The DON and MDS were educated with concentration on, but not limited to, transmission of MDS, and Envive Admission Criteria Policy. - Education and training provided to DON and MDS on 2/14/25 by the clinical support consultant. Education provided: Envive Electronic Transmission of MDS Envive Admission Criteria Policy 4: How be monitored to ensure the	

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			deficient practice will not recur i.e., what quality assurance program will be put into place? MDS/designee will complete daily monitoring to ensure that newly admitted residents have accurate level II's, will be reviewed in clinical care meeting the following weekday for accuracy 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. MDS/designee will be responsible for accurate level II's and monitoring compliance of them for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. ¿ The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. 5. Date of completion: 03/24/2025	

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F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident Based on observation, interview, and record review, the facility failed to provide an ongoing program of 1 on 1 activities for 1 of 1 residents (Resident 55) reviewed for activities. Findings include: On 2/6/25 at 10:46 a.m. Resident 55 was observed as she lay in her bed. Resident 55 indicated she did not like to get up in her wheelchair because it would cause her pain, but she did want to participate in activities. She indicated sometimes activity staff would come to visit her but they wouldn't leave her anything to do and they wouldn't stay long, so most of the time she laid in bed and watched tv. On 2/11/25 at 1:30 p.m., Resident 55's medical record was reviewed. She was a long-term care resident whose diagnoses included but were not limited to, hemiplegia (a medical condition that causes paralysis or weakness on one side of the body), cerebral infarction (stroke), and major depressive disorder. A care plan, dated 12/18/23, indicated Resident 55 was on a 1 on 1 activity schedule. The interventions for this care plan included but were not limited to, provide 1 on 1 activities as desired and tolerated. On 2/14/25 at 2:00 p.m., the Administrator provided a copy of Resident 55's individual activity visit records from December 2024 to February 2025. For the month of December, the record indicated she was visited 10 times, for the month of January the record indicated she was	F 0679	p paraid="1509141347" paraeid="{bd3bde54-f52d-453c-9365-5de5ef8a4a05}{15}" >F679 – Activities Meet Interest/Needs Each Resident “Facility failed to provide an ongoing program of 1 on 1 activities for 1 of 1 (Resident 55) reviewed for activities.” 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 55 was affected by the alleged deficient practice. Resident 55 immediately had alleged deficient practice corrected by meeting and completing a 1:1 activity. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - Residents appropriate for 1:1 activity the potential to be affected	03/24/2025

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	visited 7 times and from February 1st to February 14th she was visited 5 times. In an interview, Activity Aide 22 indicated there was a weekly schedule of activities specifically for residents who did not or could not come out of their rooms. She indicated that activity staff should be going to each of those residents rooms every day to attempt to provide activities. If the resident refused the visit that should be reflected in their 1 on 1 visit record and a revisit should have been attempted and recorded. On 2/14/25 at 2:00 p.m., a policy specific to 1 on 1 activities and visits were requested, but it was not provided. The Vice President of Clinical Services indicated they only have a policy related to activity evaluation. 3.1-33(a)		by the alleged deficient practice. Current in-house residents were audited on 3/11/25 by the director for appropriate 1:1 activity. No further actions are required. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur The DON and activities director were educated with concentration on, but not limited to, Envive Activity Evaluation Policy. - Education and training provided to DON and activities director on 3/11/25 by the clinical support consultant. - Education and training provided to activity staff on 3/12/25 by the director Education provided: Envive Activity Evaluation Policy 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DON/Activities Director/designee	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			will complete daily monitoring to ensure that newly admitted residents, or residents with changes related to appropriate 1:1 activity, have an accurate activities plan and will be reviewed in clinical care meeting the following weekday for accuracy 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. p paraid="2080483598" paraeid="{bd3bde54-f52d-453c-9365-5de5ef8a4a05}{195}" > DON/designee will be responsible for accurate 1:1 activities and monitoring compliance of them for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. ¿ The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. 5. Date of completion: 03/24/2025	

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	155077	A. BUILDING 00 B. WING	02/14/2025

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F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure a resident requesting to be sent to the hospital was assessed by a nurse and prepared to be transferred to the hospital for 1 of 3 residents reviewed for hospitalization (Resident E). Findings include: On 2/10/25 at 1:32 p.m., Resident E's medical record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, schizoaffective disorder, bipolar disorder, tobacco use, dementia with psychotic disturbance, paranoid schizophrenia, recurrent major depressive disorder, and dependence on supplemental oxygen. A nursing progress note, dated 1/12/25 at 2:07 a.m., indicated Resident E was at the reception area and went outside to smoke. He returned to the desk and informed the Receptionist that he wanted to go to the hospital. The receptionist called 911 at 11:40 p.m., and the emergency medical technician (EMT) transported the resident to a local hospital. The record lacked documentation Residnet E had been assessed and prepared for his transfer. The record lacked documentation of vital signs, patient condition, or reason for request to go to the hospital. The progress note lacked documentation that the	F 0684	p paraid="582353730" paraeid="{bd3bde54-f52d-453c-9365-5de5ef8a4a05}{233}" >F684 – Quality of Care “Facility failed to ensure a resident requesting to be sent to the hospital was assessed by a nurse and prepared to be transferred to the hospital for 1 of 3 residents reviewed for hospitalization (Resident E).” 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident E was affected by the alleged deficient practice. Resident E was already sent and returned from hospital. However, a nursing assessment was immediately completed for Resident E. 2: How other residents having the potential to be affected by the same deficient practice will be	03/24/2025

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	nurse and/or the physician was notified of his transfer to the hospital. Resident E's Leave of Absence (LOA) log was reviewed and revealed, he had not signed himself out to smoke and/or go to the hospital on the evening of 11/11/24 or the morning of 11/12/24. A Transfer-to-the-Hospital form, dated 1/12/25 at 6:37 a.m., indicated the Resident E was transferred to the hospital at 6:33 a.m. A corresponding hospital ER summary was dated 1/12/24 and indicated the Resident arrived at the ER at 12:04 in the morning, 6 hours and 33 minutes prior to facility's Transfer Form. A Nurse Practitioner (NP) progress note was entered late on 1/15/25 at 8:46 a.m., but dated effective for 1/13/25 at 3:16 p.m. The NP saw Resident E in follow up after a hospital stay. Resident E's nursing progress notes were reviewed and revealed, Resident E frequently called 911 himself for complaints of shortness of breath and/or difficulty breathing. His LOA logs were reconciled with the dates he called and transfered himself to the hopsital, and revealed he did not follow LOA policy. Resident E's care plans were reviewed and lacked implementation and/or revision of details related to his history of calling 911 himself and requests to be sent to the hospital without notifying the nurse. The Care Plans lacked implementation and/or revision or Resident E's inconsistent utalization of the LOA policy. On 2/12/25 at 11:25 a.m., the Vice President of Clinical Services (VPCS) provided a copy of		identified and what corrective action will be taken. - Residents that are currently needing hospital transfers can potentially be affected by the alleged deficient practice. Current in-house residents were audited on 3/11/25 by the DON for appropriate hospital transfer assessments. No further actions are required. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur The DON and ADON were educated with concentration on, but not limited to, Envive Change in Residents' Condition or Status Policy, and Envive Transfer or Discharge, Facility-Initiated Policy. - Education and training were provided to DON and ADON on 2/14/25 by the clinical support consultant. p paraid="1334668586" paraeid="{ae2b1eb8-6f12-43dd-8605-ee75228f5db2}{100}" > - Education provided to licensed clinical staff on 3/13/25 by DON	

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	current facility policy titled, "Discharging Resident," revised 8/2024. The policy indicated, " ...the resident should be consulted about the discharge ... if the resident is being discharged to a hospital or another facility, ensure that a transfer summary is completed and telephone report is called to the receiving facility. Assess and document the resident's condition at discharge, including skin assessment, if medical condition allows ...." 3.1-12(a)(21)		and ADON Education provided: Envive Change in Residents' Condition or Status Policy Envive Transfer or Discharge, Facility-Initiated Policy 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DON/designee will complete daily monitoring to ensure that residents needing transferred out of facility, have an accurate assessment and will be reviewed in clinical care meeting the following weekday for accuracy 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. DON/designee will be responsible for accurate transfer assessments and monitoring compliance of them for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved,	

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			an action plan will be developed. ¿ The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. 5. Date of completion: 03/24/2025	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, interview, and record review, the facility failed to ensure that a resident received necessary treatments and services to promote the healing of a pressure ulcer and prevent a new pressure ulcer from developing for 1 of 5 residents reviewed for pressure ulcers (Resident 1). Findings include: On 2/6/25 at 10:46 a.m. Resident 1 was observed in his room as he sat in his wheelchair. Resident 1 indicated the sores on his bottom just popped up one day and he was not sure what caused them. On 02/13/25 at 10:33 a.m. Resident 1's medical record was reviewed. He was a long-term care resident whose diagnoses included but were not limited to hemiplegia (a medical condition that causes paralysis or weakness on one side of the body) and dementia.	F 0686	p paraid="2147405861" paraeid="{ae2b1eb8-6f12-43dd-8605-ee75228f5db2}{186}" >F686 – Treatment/Services to Prevent/Heal Pressure Ulcer “Facility failed to ensure that a resident received necessary treatments and services to promote the healing of a pressure ulcer and prevent a new pressure ulcer from developing for 1 of 5 residents reviewed for pressure ulcers (Resident 1).” 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	03/24/2025

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	A skin and wound note, on 12/12/24, indicated Resident 1 had an abscess on the back of his left thigh, an unstageable pressure ulcer to his right buttock and a stage 3 (full thickness tissue loss where subcutaneous fat is visible) pressure ulcer to the back of his right thigh in the gluteal fold (space between the buttocks and upper thigh). The note indicated the treatment recommendations included but were not limited to, the need for a LAL mattress. A skin and wound note from 12/19/24 indicated that Resident 1 had a new stage 2 (partial thickness skin loss which presents as a shallow open area with a pink or red wound bed) pressure ulcer on the left buttock. It was again recommended that the resident have a LAL mattress. Resident 1 had a active order for a low air loss (LAL) mattress dated 12/20/24. On 2/14/25 at 2:00 p.m., the Administrator provided a copy of a current facility policy titled, "Support Surface Guidelines" dated 8/2024. The policy indicated, " ...7. Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface such as foam, gel, static air, alternating air, air loss or gel when lying in bed ...." On 2/14/25 at 2:00 p.m., the administrator provided a copy of a current facility policy titled, "Prevention of Pressure Injuries" dated 8/2024. The policy indicated, " ...20. Select appropriate support surfaces based on the residents risk factors in accordance with current clinical practice ...". 3.1-40		Resident 1 was affected by the alleged deficient practice. Resident 1 immediately had treatments and services reviewed for skin and wounds and updated as appropriate for prevention and healing. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - Residents that that are at risk for skin breakdown can potentially be affected by the alleged deficient practice. ul class="BulletListStyle1 SCXW183855009 BCX8" role="list" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; font-family: verdana; overflow: visible;" Current in-house residents were audited on 3/10/25 by for appropriate skin and wound treatments. No further actions are required.	

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			3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur The DON and ADON were educated with concentration on, but not limited to, Envive Prevention of Pressure Injuries Procedure, and Envive Wound Care Procedure. - Education and training were provided to DON and ADON on 3/10/25 by the clinical support consultant. - Education and training provided to licensed clinical staff on 3/13/25 by DON Education provided: Envive Prevention of Pressure Injuries Procedure Envive Wound Care Procedure 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DON/designee will complete weekly monitoring to ensure accurate assessment and skin prevention, and wound healing treatments are accurate, and they	

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			will be reviewed in clinical care meetings weekly for 8 weeks, then monthly in QAPI for 6 months. DON/designee will be responsible for skin prevention and wound healing treatment monitoring for compliance for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. ¿ The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. 5. Date of completion: 03/24/2025	
F 0687 SS=D Bldg. 00	483.25(b)(2)(i)(ii) Foot Care Based on observation, interview, and record review, the facility failed to ensure a resident recieved assistance with toenail care provided by podiatry (a medical specialty that focuses on feet, ankles and legs) for 1 of 3 residents reviewed for ADL care (Resident 66).	F 0687	F687 – Foot Care “Facility failed to ensure a resident received assistance with toenail care provided by podiatry (a medical specialty that focuses on feet, ankles and legs) for 1 of 3 residents reviewed for ADL care (Resident 66).”	03/24/2025

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	Findings include: On 2/6/25 at 10:46 a.m., Resident 66 was observed. He appeared to be unkempt and there was a strong cigarette odor. His toenails on both feet were long, rough, thick and discolored. His fingernails were long and discolored. The Resident indicated podiatry was supposed to come and cut his toenails, but they had not come yet. Resident 66 indicated the last time he had to "rip" his toe nails off because no one would come to cut them. On 2/12/25 at 9:42 a.m., Resident 66 was observed as he smoked outside. He indicated he still had not gotten his finger or toenails cut. On 2/11/25 at 9:55 a.m., Resident 66's medical record was reviewed. He was a long-term care resident whose diagnoses included but were not limited to chronic obstructive pulmonary disorder (COPD) and schizophrenia. He had an active physician's order to recieve podiatry services. A skin and wound note, dated 1/9/25, indicated the Nurse Practitioner (NP) recommended a podiatry consult for nail trimming and thickened toenails. An NP progress note, dated 1/17/25, indicated Resident 66 was seen by the NP for right foot pain between his toes. The note indicated the NP placed the resident on the podiatry list. On 2/12/25 at 9:30 a.m., a podiatry schedule was provided by the Administrator (ADM). The podiatry schedule indicated they came to the facility on 1/21/25 and on 2/6/25. Podiatry was due		1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ul class="BulletListStyle1 SCXW73203247 BCX8" role="list" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; font-family: verdana; overflow: visible;" Resident 66 was affected by the alleged deficient practice. Resident 66 was immediately assessed for need for foot care. Resident seen by podiatry on 3/14/25. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - Residents that are currently needing foot care can potentially be affected by the alleged deficient practice. Current in-house residents were audited on 02/19/25 by the DON/SSD for the need for podiatry care. If is found, they will be added to to see podiatry on next	

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	to come again on 3/24/25. Resident 66 was not on the list to be seen. On 2/14/25 at 2:20 p.m., the ADM provided a copy of a current facility policy titled, "Care of Fingernails, Toenails," dated 8/2024. The policy indicated, " ...4. Proper nail care can aide in the prevention of skin problems around the nail bed ...". On 2/14/25 at 2:20 p.m., the ADM provided a copy of a current facility policy titled, "Activities of Daily Living (ADLs), Supporting," dated 8/2024. The policy indicated, " ... Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene ...." 3.1-47(a)(7)		visit. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur DON/ADON/SSD were educated with concentration on, but not limited to, Envive Care of Fingernails and Toenails Procedure and Envive Foot Care Procedure was provided to DON and activities director on 2/17/25 by the clinical support consultant. Education provided: Envive Care of Fingernails and Toenails Procedure Envive Foot Care Procedure 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DON/designee will complete weekly monitoring to ensure that residents needing foot care will be reviewed in clinical care meeting the following weekday to address and/or schedule for podiatry weekly for 8 weeks, then monthly	

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			in QAPI for 6 months. DON/designee will be responsible for foot care and podiatry scheduling and/or visits for compliance of them for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. ¿ The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. 5. Date of completion: 03/24/2025	
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure that residents who chose to smoke had accurate and current Smoking Safety assessments and interventions; and the facility failed to have clear, concise, and consistent policies and procedures for independent versus supervised smokers, and storage and accountability of smoking materials. These deficient practices had the potential to affect 30 of 56 residents reviewed for smoking	F 0689	p paraid="1813376059" paraeid="{8941a9f5-0aab-4d36-9c22-7a92592663ac}{106}" >F689 – Free of Accident Hazards/Supervision/Devices “Facility failed to ensure that residents who chose to smoke had accurate and current Smoking	03/24/2025

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	(Residents D, E, G, J, K, 1, 6, 8, 13, 14, 19, 21, 28, 35, 44, 46, 49, 52, 56, 62, 66, 76, 78, 80, 81, 88, 92, 103, 264 and 309). Findings include: During a confidential interview, the interviewee indicated the facility "supposedly" had a strict smoking policy, but the policy was never enforced. There were many residents who were unsafe to smoke who continued to make bad smoking choices and got away with it. Every resident was allowed to keep their own materials, so it was impossible to know who had what, and how much they had at any given time. Residents were supposed to sign out on Leave of Absence (LOA) to go smoke. Maybe they did, maybe they didn't. There was no way to know if they signed LOA. Several residents would sit or stand under the front entrance awning to smoke right by the front doors so that EMS couldn't get in without having to shuffle everyone around. No one enforced the smoking policy and many of the nurses were fed up with the behaviors, arguments and complications that arose from the issue of smoking. It was indicated, staff were afraid to come to work sometimes because how widespread the smoking problem was, and they were afraid a Resident might blow up the building. Resident E even after his accident with smoking continued to try and sneak around to get cigarettes and smoke. It was indicated, if nursing was notified that Resident E had smoking material, they would go down and tell him to hand it over. He would rummage through his pockets, his walker basket and bedside drawers and hand over cigarettes and lighters. Resident E was just "another accident" waiting to happen. 1. An Indiana Department of Health (IDOH)		Safety assessments and interventions; and the facility failed to have clear, concise, and consistent policies and procedures for independent versus supervised smokers, and storage and accountability of smoking materials. These deficient practices had the potential to affect 30 of 56 residents reviewed for smoking (Residents D, E, G, J, K, 1, 6, 8, 13, 14, 19, 21, 28, 35, 44, 46, 49, 52, 56, 62, 66, 76, 78, 80, 81, 88, 92, 103, 264 and 309)." 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents D, E, G, J, K, 1, 6, 8, 13, 14, 19, 21, 28, 35, 44, 46, 49, 52, 56, 62, 66, 76, 78, 80, 81, 88, 92, 103, 264 and 309 affected by the alleged deficient practice. Residents D, E, G, J, K, 1, 6, 8, 13, 14, 19, 21, 28, 35, 44, 46, 49, 52, 56, 62, 66, 76, 78, 80, 81, 88, 92, 103, 264 and 309 immediately for smoking privileges and safety concerns. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	

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	Facility Reported Incident report, dated 1/13/25, indicated the local hospital called the facility and informed the facility that Resident E received a facial burn during the resident's transport back to the facility. The report indicated, "resident was being transported back to his ECF [extended care facility] when he lit a cigarette in the transport vehicle causing burns to his face." The resident was returned to the hospital for treatment. On 1/14/25 the resident returned to the facility with deep partial thickness burns to the face. Preventive measures added on 1/14/25 indicated the resident's care plan had been reviewed and revised, and the resident was educated on oxygen safety. During a confidential interview, the interviewee indicated, Resident E was very impulsive and changed his mind a lot about wanting to smoke, verses, wanting to quit. Even since his accident he still tried to get away with smoking and had been caught several times with cigarettes and the nurses had to confiscate the material. It was impossible to know when or who he got smoking material from because so many other residents smoked and kept their materials with them, he could easily "steal it," or just ask his friends and they would give him smoking materials. Resident E was not consistent with signing out to go Leave of Absence (LOA) and because there were so many unsafe smokers in the building, Resident E could get hurt again very easily. During a confidential interview, the interviewee indicated Resident E was sometimes confused. Some days he seemed normal, but other days he would say things or forget things and do things that made him seem more confused than normal. He still tried to go out with everyone to smoke, but staff were not supposed to let him smoke		action will be taken. - Current smoking residents were re-assessed with smoking privileges and safety concerns. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur DON and ADON were educated with concentration on, but not limited to, Envive Healthcare Smoking Policy provided to DON and activities director on 2/12/25 by the clinical support consultant. Education and training provided to facility staff on 2/12/25 by ED and DON Education provided: Envive Smoking Policy 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DON/designee will complete weekly monitoring to ensure that newly admitted residents have a completed smoking assessment, and currently admitted residents	

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	since his accident until his burns healed. Lighters and cigarettes had been confiscated from Resident E, even after his accident. During a confidential interview, the interviewee indicated Resident E was confused a lot of the time. He was also noncompliant with a lot of his orders. For example, he would ask repeatedly for his breathing treatment, but then only take the treatment for a couple minutes before he got up and left his room. He would complain of shortness of breath but then go outside to smoke. One day he would want to quit smoking and request nicotine patches, then the next day he would be right back to demanding cigarettes to go smoke. Resident E was not a safe smoker, "obviously because he lit a cigarette when he was wearing oxygen on his face and got burned up." After his accident he was allowed only to go outside to smoke with supervision, but he was a friendly guy, and he asked his peers for help, and they gave him cigarettes and lights. Staff had to go and take away smoking supplies. He still signed himself out LOA, but he did not always sign the book or tell the nurses where he was going or when he would be back. During an interview on 2/11/25 at 10:49 a.m., with the Administrator (ADM) and Director of Nursing (DON) present, the ADM indicated, Resident E was a difficult case because of his psychiatric behaviors. He was indecisive and changed his mind often and frequently about his desire to quit smoking. He would want to quit and then demand more smoking materials and time to smoke. Resident E was "on again off again" with his requests for nicotine patches, and he even came to the ADM's window, knocked on the glass with a lit cigarette in his mouth and pointed to the nicotine patch on his arm in jest to the ADM. The		have quarterly assessments and will be reviewed in clinical care meeting the following weekday for 8 weeks, then monthly in QAPI for 6 months. DON/designee will be responsible for smoking assessment completeness and accuracy compliance for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. ¿ The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. 5. Date of completion: 03/24/2025	

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	ADM indicated after the accident staff talked to Resident E about what happened and did a search of his room but found nothing. The ADM indicated there was no documentation related to the conversation or room search, and no further investigation had been conducted related to his accident. During an interview on 2/12/25 at 10:01 a.m., Resident H indicated he was fed up with Resident E, whom he shared an adjoining bathroom with. Resident H knew Resident E smoked in his room because the bathroom would smell very strongly of smoke that would leak into his room. Resident E was not supposed to smoke after he blew his face up, but that did not stop him from sneaking cigarettes at night. Resident H would find cigarette butts and ash in and/or on the toilet. He complained to nursing staff who just said they would check it out. Resident H indicated he was afraid to be next door to Resident E in case he tried to smoke with his oxygen on again and cause an explosion. During an interview on 2/12/25 at 10:37 a.m., the ADM confirmed Resident E was not allowed to smoke until his burns were fully healed. Resident E's record lacked documentation that he had been educated, and/or agreed to quit smoking while his facial injuries healed and lacked documentation that any smoking assessment/evaluation had been completed as he continued to be non-compliant. During an interview on 2/12/25 at 10:40 a.m., the Social Service Director (SSD) indicated the majority of Resident E's behaviors were related to his psychiatric diagnoses. His behavior patterns were intermittent and random. One minute he might scream down the hallway, then in the next			

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	few minutes smile and act like nothing happened. Especially with his bipolar, it was all very random. Smoking was definitely one of his biggest triggers before his accident. In the past Resident E had been "pretty slick" and persuasive with his peers and/or visitors to ask for and get smoking materials from them. He would go back and forth from wanting to quit smoking and asking for nicotine patches, then demanded cigarettes. The SSD indicated staff talked with Resident E after the accident and the room was searched, but did not see that it had been documented. The SSD reviewed Resident E's record and indicated she did not see documentation of a smoking safety assessment upon his return to the facility after burning his face smoking with oxygen. The SSD then reviewed Resident E's care plans and indicated they had not been revised to include details of the accident and/or interventions to prevent something like that from happening again. On 2/10/25 at 1:32 p.m., Resident E's medical record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, schizoaffective disorder, bipolar disorder, tobacco use, dementia with psychotic disturbance, paranoid schizophrenia, recurrent major depressive disorder, dependence on supplemental oxygen, and burn of third degree of head, face and neck. A care plan, initiated on 8/31/23 and revised on 7/29/24, indicated he had impaired cognitive function and impaired thought processes related to his diagnoses of unspecified dementia, psychotic disturbance, mood disturbance and anxiety. He was at risk for decline and had a history of scoring low on BIMS (brief interview for mental status) cognitive test. Interventions included, but were not limited to, assist him to			

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	make safe decisions, discuss concerns about confusion and assess cognition on quarterly, annual and as needed with significant changes. The care plan lacked revision to address poor safety choices related to smoking while wearing oxygen after the incident on 1/13/25. A care plan, initiated on 10/24/23 and revised on 7/29/24 indicated he had behaviors of becoming verbally aggressive towards others, used abusive language, cursed at others, physically aggressive towards others, agitated, refused care, refused medications, refused to wear oxygen, had impulsive behaviors, manipulation and non-compliance with his diet. He had a history of behaviors of pulling cigarette butts from ash tray and reusing them. He frequently changed his decision about smoking cigarettes and continued to have outbursts when his wants were not provided as quickly as he preferred. He asked for a nicotine patch to assist with smoking cessation but continued to smoke and express frustrations. Interventions for this plan of care included, but were not limited to, assess and anticipate his needs and assess his understanding of the situation. The care plan lacked revision to address poor safety choices related to smoking while wearing oxygen after the incident on 1/13/25. A care plan, initiated on 7/19/25 and revised on 4/30/24, indicated he desired to use tobacco products i.e. Cigarettes and had a history of pulling cigarette butts from ash tray to reuse. He frequently changed his decisions about smoking cigarettes. Interventions for this plan of care included, but were not limited to, smoking assessments as indicated and to ensure smoking materials are stored per facility policy. The care plan lacked revision to address poor safety choices related to smoking while wearing oxygen			

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	after the incident on 1/13/25. A care plan, initiated on 1/15/25, indicated he required the use of oxygen therapy related to his respiratory failure. The care plan lacked revision to include safe smoking practices to prevent the potential for accidents while using oxygen. The full care plan set lacked documentation of implementation and/or revision to include the IDT decision that Resident E should not smoke until his facial burns and injuries healed. The care plan lacked revision/documentation that Resident E had been educated and demonstrated safe smoking habits. The care plan lacked implementation/revision to address Resident E's ability to appropriately adhere to the LOA policy. A quarterly Minium Data Set assessment, dated 10/12/24, indicated Resident E was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. Resident E had a quarterly Safe Smoking Evaluation dated 10/28/24. The record lacked documentation that an additional Safe Smoking Evaluation had been completed after the incident on 1/13/25. A nursing progress note, dated 1/12/25 at 2:07 a.m., indicated Resident E was at the reception area and went outside to smoke. He informed the Receptionist that he wanted to go to the hospital. The receptionist called 911 at 11:40 p.m., and the emergency medical technician (EMT) transported the resident to a local hospital. A hospital summary, dated 1/13/25, indicated, " ...he was being transported back to his ECF [extended care facility] when he lit a cigarette in			

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	the transport vehicle causing a small explosion and burns to his face. He was brough immediately back to the ED [emergency department] for evaluation ...." A Nurse Practitioner (NP) progress note was entered late on 1/15/25 at 8:46 a.m., but dated effective for 1/13/25 at 3:16 p.m. The NP saw Resident E in follow up after a hospital stay. " ...Nursing reports that patient sustained a full thickness burn to the face in the EMS while being transported back to the facility. Nursing reports that patient lit a cigarette while in the ambulance. Patient taken back to ER and released back to the facility after assessment and treatment. Patient returned from hospital with head and face bandaged with gauze dressing. The NP provided smoking cessation education ...patient continues to ask for Nicotine patches and smokes when given patches. Patches discontinued ...Patient educated on the following risk factors: Acute risks: Continued shortness of breath and risk of respiratory infection. Long-term risks: Heart attacks and strokes, lung and continued exacerbation of chronic obstructive pulmonary diseases. Patient reports that he is not ready to quit smoking. Patient continues to smoke cigarettes. Patient has had several attempts at Nicotine Patches. Patient continues to smoke during attempts ...." The NP note lacked documentation that education had been provided to Resident E about the dangers of smoking while wearing oxygen. A nursing progress note, dated 1/13/25 at 7:38 p.m., indicated Resident E returned from the hospital with new burns to his face. The NP saw the resident and Resident E was educated that he could not smoke but lacked documentation of the Resident's agreement and/or refusal to comply.			

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A nursing progress note, dated 1/14/25 at 6:45 p.m., indicated Resident E was found to have a cigar in his possession. The Charge nurse was instructed to confiscate the cigar as the Interdisciplinary team (IDT) had determined he was not allowed to smoke until his injuries had healed from his recent injuries related to smoking with oxygen in use. The Charge Nurse was able to retrieve cigar, lighter, and additional cigarettes from Resident E after several attempts.

The record lacked documentation of a smoking assessment/evaluation, a BIMS evaluation and/or implementation/revision of the Resident's care plan to address his ability to obtain smoking materials, agreement to comply with temporary "no-smoking" and/or mental capacity to continue to makes safe smoking choices after he was found with smoking materials that he refused to give up without several attempts at redirection on 1/14/25.

A nursing progress note, dated 1/15/25 at 12:52 p.m., indicated Resident E made several attempts to go outside and smoke with his portable oxygen still in place as well as kerlix dressings to his face. Resident E was difficult to redirect and yelled and cursed at staff. He blocked the entrance to the facility preventing anyone else from coming in or out. He became physically aggressive with the nurse as he repeatedly pushed his wheelchair into the nurse's legs. Eventually he was assisted back to his room. This note lacked documentation the physician had been notified.

The record lacked documentation of a smoking assessment/evaluation, a BIMS evaluation and/or implementation/revision of the Resident's care plan to address his ability to obtain smoking materials, agreement to comply with temporary

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	"no-smoking" and/or mental capacity to continue to makes safe smoking choices after he exhibited aggressive behaviors and attempted to go outside to smoke with his portable oxygen still in place on 1/15/25. A nursing progress note, dated 1/15/25 at 1:11 p.m., indicated Resident E continued to be upset and was initially unsuccessful to redirect him. He yelled and cured and made threatening gestures. Staff attempted to call his girlfriend, but she was unavailable and Resident E walked away cussing. An IDT progress note, dated 1/15/25 at 2:12 p.m., indicated Resident E was recommended for in-patient psychiatric care due to his non-compliance with his smoking cessation regimen. The record lacked documentation of neuro-psych hospital records. During an interview on 2/12/25 at 10:33 a.m., the ADM and RNC indicated Resident E was in transport to neuro-psych but became agitated and began to remove his bandages and facial dressing. Upon arrival to neuro-psych they declined to accept him due to the severity of his wounds and clinical needs. He was then transported to a local ER and returned to the facility shortly after. A NP progress note was entered late on 1/19/25 at 11:23 a.m., but dated effective for 1/16/25 at 11:30 a.m., The NP saw Resident E in follow up for another ER visit which occurred on 1/15/25. Nursing staff reported he went out to the ER with shortness of breath, but returned with no new orders. During the NP's assessment, Resident E was noted to be alert and oriented, but had			

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	periods of delusions, confusion and aggression. A Social Service progress note, dated 1/17/25 at 3:39 p.m., indicated Resident E had continued to be non-compliant with wound care and the smoking policy. The SSD spoke with Neuro-psych about intake/referral on 1/15/25 but found out when Resident E arrived at their hospital, they did not realize how medically complex he was regarding the recent burns on his face. Resident E would continue to be seen by the rounding Psych NP. A Psych NP note, dated 1/17/25 at 4:22 p.m., indicated Resident E was seen in his bed, in a good mood, and continued to recover from the burns on his face sustained by smoking on oxygen. Per his medical chart review, Resident E had recently attempted multiple times to smoke inside or while on oxygen. He was transferred to the hospital and neuro-psych hospital, but was not admitted for evaluation and instead transferred to a local medical hospital for SOB. The dangers of smoking while on oxygen was reiterated, and he appeared to listen. Resident was encouraged him to participate with medical staff in wound care. The Psych NP note lacked clarification that there were not medical records from a neuro-psych in-patient stay on 1/15/25 as he had not been admitted. The NP note, and Resident E's medical record lacked documentation of Resident E's understanding after "re-education," and lacked implementation of new goals/interventions in an attempt to keep him safe even after he demonstrated increased aggressive behaviors, obtained smoking material and attempted to smoke with oxygen still in place.			

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	A NP progress note, dated 1/20/25 at 5:23 p.m., indicated Resident was noted to be alert and orients, but had periods of delusions, confusion and aggression. A nursing progress note, dated 1/26/25 at 11:58 p.m., indicated Resident E returned from the hospital awake and alert with confusion. A NP progress note, dated 1/30/25 at 1:37 p.m. indicated Resident was noted to be alert and oriented, but had periods of delusions, confusion and aggression. A NP progress note, dated 1/31/25 at 2:00 p.m., indicated, Resident E was seen for follow up to lab work and a pulmonary appointment, " ...patient continues to be dyspneic related to COPD and continued smoking ...." Resident E's physician orders were reviewed and lacked documentation of the physician's awareness and/or order to use tobacco products and that he was safe to do so. He had a current physician's order to wear oxygen via a nasal canula at 4 liters with a note that he might remove it at times and no specification not to smoke while wearing his oxygen. Resident E's physician orders lacked documentation for monitoring safe smoking habits after his accident on 1/13/25, and continued behaviors on 1/14/25 and 1/15/25. Resident E's record lacked documentation that a comprehensive Smoking Safety evaluation was completed to determine his appropriateness and ability to continue to smoke independently.			

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	A Quarterly/Annual nursing assessment, dated 1/27/25, which included a smoking evaluation section, indicated Resident E did not smoke, therefore, no further evaluation was conducted. A Clinical Risk Assessment, dated 1/15/25, was conducted upon his return from the hospital. A section for behaviors indicated to check any that applied and/or select and describe "other." No behaviors were selected or described. The assessment lacked documentation of the behaviors documented in the progress notes for 1/14 and 1/15 and his continued attempts to smoke and becoming aggressive when redirected. No new recommendations, modifications and/or notifications were noted. Resident E had a signed smoking policy scanned in, but it was undated and did not indicate if it was for routine review, or after the accident re-education. Further, the policy lacked specifications for using the LOA policy to sign out and smoke. Resident E's LOA logs were reviewed and revealed, he continued to sign himself out LOA on a frequent basis. The log had sections for the date, time with a.m. or p.m., yes or no if the oxygen tank was full or "na" if no oxygen in use, signature of person accepting responsibility for resident, anticipated date/time of return, date (2nd time), time (second time), and signature of person assisting resident back to facility or facility staff witnessing resident return. The January log indicated Resident E had filled out the sections on the LOA form or the sections were left blank. The log lacked signature of staff witnessing resident return. The form lacked documentation of if Resident E left his oxygen inside when he smoked outside.			

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	During an interview on 2/12/25 at 1:43 p.m., VPCS indicated the facility's LOA policy was all incumbent and initially reviewed on admission and quarterly thereafter. Residents that were independent smokers signed out LOA. The smoking policy did not reference the LOA policy, and the LOA policy did not reference the smoking policy. Resident E used to have a physician's statement which indicated, "MD is aware of resident choice to use tobacco products," but he did not have a current physician statement. Residents that used oxygen and still chose to smoke, should take their oxygen off at the door and leave it inside before going out to smoke. During an interview on 2/12/25 at 4:38 p.m., the Chief Operating Officer indicated the facility could not be held responsible for that happened off facility property, and because Resident E had not been adjudicated by a court and deemed incompetent to make his own choices, therefore the facility could not take away his rights, which included his right to smoke. 2. On 2/14/25 at 10:00 a.m., Resident 6's medical record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, traumatic brain injury, paranoid schizophrenia, psychoactive substance abuse, and mild intellectual disabilities. An admission MDS assessment, dated 12/11/24, indicated he was cognitively intact with a BIMS score of 15. A Safe Smoking Evaluation, dated 11/20/24, indicated Resident 6 understood the Smoking Policy and could not store smoking materials in his room. The Evaluation did not specify he was			

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	safe to be an independent smoker. A nursing progress note, dated 11/21/24 at 5:52 p.m., indicated Resident 6 began to repeatedly ask to be taken outdoors to smoke cigarettes outside of scheduled smoke breaks. Staff assisted with taking outdoors during scheduled smoke breaks, but Resident 6 was noted to be rude to staff when unable to smoke outside of scheduled time. He yelled at staff with profanity. He was unable to be re-directed and had to be removed from other residents for safety concerns. A nursing progress note, dated 12/7/24 at 6:49 p.m., indicated Resident 6's mother did not want him to smoke anymore and she preferred him to have nicotine gum instead. " ...he shouldn't be going outside to smoke, per her request." His mother spoke with him, and convinced him to stop smoking, at least until his wound healed. Resident 6 agreed to stop smoking temporarily. The record lacked documentation of any court determination that Resident 6 had deemed incompetent, and his mother had been made his guardian. The record lacked documentation of revision to his care plan to temporarily stop smoking until his wound healed. A nursing progress note, dated 12/10/24 at 7:04 p.m., indicated Resident 6 obtained smoking materials from a delivery person who was unaware of his medical history. When staff attempted to take the smoking material from him, it caused him to have increased behaviors. He cursed and called staff names and became "very belligerent" toward staff. He continued to ambulate through the facility looking for ways to smoke. His mother was			

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	155077	A. BUILDING 00 B. WING	02/14/2025

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	notified, but the progress note lacked documentation the physician had been notified. A nursing progress note, dated 12/17/24 at 10:55 a.m., indicated Resident 6 returned from a hospital stay and immediately began to yell for the Executive Director (ED). Resident 6 indicated, "I want my cigarettes and all of my shit ... I don't give a f*** what my mother says." A nursing progress note, dated 12/17/24 at 11:38 a.m., indicated Resident 6 continued to have behaviors and put himself on the floor and screamed for the ED. He continued to yell, " ...I want my F****** cigarettes, [ED's name] is not by Dad!" He was unable to be redirected, he refused to calm down and refused to return to bed and cover up as he was completely naked. The note lacked documentation the physician had been notified. A nursing progress note, dated 1/17/25 at 3:47 a.m., indicated Resident 6 was found to be smoking a cigarette in his room. He was reminded smoking in the facility was strictly not allowed, but he refused to put it on. He became very upset and refused to give up the cigarettes. The note lacked documentation, the physician and or the ED were notified. A nursing progress note, dated 1/21/25 at 7:02 a.m., indicated staff found Resident 6 to have a cigarette pack with a lighter in it, and was suspected of smoking in his room. The note lacked documentation, the physician and or the ED were notified. A nursing progress note, dated 1/24/25 at 6:23 p.m., Resident 6 was found in his room smoking a cigarette. The nurse attempted to confiscate the			

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	lighter, but he became combative and the light was not retrieved. After Resident 6 was witnessed smoking in his room on 1/17, 1/21, and 1/24, the record lacked revision to his care plans to include new interventions to address his non-compliance with the smoking policy. The resident's record lacked reassessment of Resident 6's preference to smoke. Resident 6's care plan lacked documentation/revision to specify the Resident's mother was allowed to make decisions for him and/or was his guardian. The care plan lacked revision to include his history of smoking in the facility. Resident 6's record lacked documentation of a Smoking Safety evaluation after he was discovered smoking in his room. The record lacked documentation of any implemented consequences as outlined by the Smoking Policy if residents were found to be non-compliant. 3. On 2/14/25 at 10:00 a.m., Resident 80's medical record was reviewed. He was a long-term care resident with diagnoses which included but were not limited to chronic obstructive pulmonary disease (COPD), schizophrenia, and major depressive disorder. A nursing progress note, dated 12/18/24 at 5:52 a.m., indicated Resident 80 was "witnessed with hair on fire from cigarette." His hair on the left top side of his head was noted to be "frizzed." The note lacked documentation the physician and or the ED had been notified.			

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	A late NP progress note, dated 12/19/24 at 2:30 p.m. (created 12/26/24), indicated the NP visited Resident 80 for a routine visit and follow up to the incident where he set his hair on fire. "...Patient reports that his hair caught on fire while he was smoking. Patient stated, 'I will not do it again.' Patient educated regarding safety during smoking. Patient educated going forward he will need to be supervised while smoking for his safety. Patient very upset. Patient stated, 'Everyone needs to be supervised then.' Writer again educated the patient that he will be allowed to go and smoke but he will have to be supervised ..." The record lacked documentation that a Smoking Safety evaluation had been completed after his accident on 12/18/24. 4. On 2/14/24 at 10:00 a.m., as part of an expanded sample related to a pattern of unsafe smoking procedures observed throughout the survey period, it was discovered that 5 residents refused to sign the Smoking Policy. On 2/12/24 Residents D, 21, 52, 56, and 80 refused to sign the facility's Smoking Policy. The resident's records were reviewed and lacked documentation a person-centered, individualized plan of care to address their refusal to acknowledge the Smoking Policy and a plan on how to move forward to protect them and the other residents of the community. 5. On 2/6/25 at 10:27 a.m., Resident 49 was observed as he independently ambulated through the hallway with an unlit cigarette hanging from his mouth.			

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	On 2/6/25 at 10:30 a.m., Resident 8 was observed in his room. He indicated he had a vape that he kept with him and he and his girlfriend both vaped in their rooms whenever they wanted. On 2/6/25 at 11:42 a.m., during an interview with Resident 66, a fresh, strong odor of cigarette smoke was noted. On 2/7/25 at 1:18 p.m., Resident 309 was observed in the hallway as he talked with 4 unidentified staff members. A pack of cigarettes was observed in his breast pocket. On 2/11/25 at 9:21 a.m., Resident 264 was observed at the B Hall nurses station and a red lighter was plainly visible on top of his lap. On 2/11/25 at 2:50 p.m., Resident 62 was observed as he walked down the hall with an unlit self-rolled cigarette in his mouth. On 2/12/25 at 9:24 a.m., Resident 28 was observed, as he independently ambulated in his wheelchair into the therapy gym. A black and white patterned lighter was observed clipped to a retractable key chain lanyard clipped to the outside of his jacket. During an interview on 2/12/25 at 10:57 a.m., Resident 92 indicated he kept his cigarettes in his pocket so he would not lose them. As he walked out of his room and stepped into the hallway at the back of C Hall, he indicated, "wow, it smells like marijuana out here." During a confidential interview, it was indicated there was one resident, Resident 6, who smoked in his room a lot. He was at the hospital now, but if he returned, he would probably still smoke in his room.			

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	During an interview on 2/12/25 at 11:03 a.m., Resident 35 indicated the activity department kept his cigarettes for him, but he was allowed to keep his own lighter. On 2/12/25 at 11:47 a.m., Resident G was observed. She was in the common activity area and had a purse hanging from her walker, she opened it and showed that she kept some cigarettes. She indicated she shared cigarettes with other residents who were her friends, because they shared with her too. On 2/14/24 at 10:00 a.m., as part of an expanded sample related to a pattern of unsafe smoking procedures observed throughout the survey period, the records of those residents who smoke were reviewed for up-to-date Smoking Safety Evaluations. During the survey entrance conference on 2/6/25 at 10:06 a.m., a current list of residents that smoke provided by the ED. There were 56 residents on the list. Residents E, J and K were listed as residents who currently smoked but also required the use of oxygen therapy. Their plan of care lacked personalized interventions to address their smoking habits in conjunction with their preferences and choice to smoke. Residents 88, 46, 81, 60, E, 62, 19, 49, D, 78, K, 264, 44, 13, 66, 1, 103, 56 and 76, (19 of 52 smoking residents) did not have up to date routine/quarterly and/or as needed Smoking			

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	Safety Assessments. The Smoking Safety Assessments lacked documentation if the residents were an independent smoker or supervised smoker. The Smoking Safety Assessments indicated, " ...9. Resident expresses understanding that all smoking material/smokeless tobacco products are to be stored with facility and not in resident's room?" The only options were yes or no. The Smoking Safety Assessment lacked documentation on if the resident could keep smoking supplies in their rooms or on their persons. 6. During the survey entrance conference, a current copy of the facility smoking policy was requested and provided by the ADM. The policy was titled, "Smoking Policy- Residents," revised 8/2024. The policy indicated, "The facility has established and maintains safe resident smoking practices ... smoking is not allowed inside the facility under and circumstances ...oxygen use is prohibited in smoking areas ... residents smoking status is evaluated upon admission. If a smoker, the evaluation includes: current level of tobacco consumption, method of tobacco consumption, desire to quit smoking and ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). The staff consults with the attending physician and the director of nursing services (DNS) to determine if safety			

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	restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff ... the facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision ... Residents are not permitted to give smoking items to other residents ...." The policy did not address the residents' requirements to sign themselves out to go smoke.The policy did not give measurable, quantifiable and/or detailed instructions or procedures for implementing consequences. The policy did not give direction or instruction for residents who chose to smoke while require the use of Oxygen therapy. On 2/12/25 at 11:25 a.m., the VPCS provided a copy of the current facility policy titled, "Guidelines for LOA," revised 6/2023. The policy indicated, "Purpose: to ensure responsible party and/or resident has knowledge of medication administration, precautions and activity level when leaving or discharging from the campus ... if at all possible, a physician order should be written for LOA privileges including, but not limited to, BIMS score, safety concerns and/or resident condition ... a sign-out log should be available for the resident or			

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	responsible party to sign out prior to leaving the campus for a leave of absence ... If the leave is spontaneous the nurse should prepare the medications needed during the leave. The LOA/Discharge should be documented and include written medication administration, precaution and activity level instructions given to resident/responsible party ... nursing documentation should include: the date and time the resident left, who they left with, expected time of return, instructions provided, medications sent (type and number of doses). The policy did not address a procedure for LOA specific to the facility smoking procedure and practices. The policy did not give measurable, quantifiable and/or detailed instructions or procedures for re-assessing a resident's ability to sign out LOA.On 2/13/25 at 1:53 p.m., the VPCS provided a copy of current facility policy titled, "Oxygen Administration," revised 8/2024. The policy indicated, "The purpose of this procedure is to provide guidelines for safe oxygen administration ... place an "Oxygen in Use" sign on the outside of the room entrance door ... instruct the resident, his/her family, visitors and roommate (if any) of the oxygen safety precautions. Provide the resident with a written copy of the Oxygen Safety hanout ...." The policy lacked specifications/instructions for removing			

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	oxygen for residents who smoke. The policy lacked a copy of the Smoking Safety Handout and/or that residents reviewed a copy of the hanout in their medical record. 3.1-45(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, interview, and record review, the facility failed to evaluate and address the nutritional status of a resident which resulted in an 11.26 percent (%) weight loss in two months for 1 of 5 residents reviewed for nutrition (Resident 1). Findings include: On 2/6/25 at 10:46 a.m., Resident 1 was observed in his room as he sat in his wheelchair. The resident indicated he had sores on his bottom that just popped up one day, and he was not sure how they started. On 2/13/25 at 10:33 a.m., Resident 1's medical record was reviewed. He was a long-term care resident whose diagnoses included but were not limited to hemiplegia (a medical condition that causes paralysis or weakness on one side of the body), major depressive disorder, dementia, and obsessive-compulsive disorder. His vital records were reviewed and revealed, on 11/12/24, the resident weighed 231 pounds. On 1/13/25, the resident weighed 205 pounds which was an 11.26 % loss in two months. Resident 1's physician orders were reviewed. There were no active orders for any nutritional supplements.	F 0692	p paraid="527779757" paraeid="{ca696aa7-bb65-46ef-bf61-29004dec1df0}{31}" >F692 – Nutrition/Hydration Status Maintenance “Facility failed to evaluate and address the nutritional status of a resident which resulted in an 11.26 percent (%) weight loss in two months for 1 of 5 residents reviewed for nutrition (Resident 1).” 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 1 was affected by the alleged deficient practice. Resident 1 immediately had alleged deficient practice corrected by having nutritional status reviewed by a dietician.	03/24/2025

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	A critical risk assessment (CAR), dated 1/2/25, indicated Resident 1's weight was 231 pounds, nutritional supplements were not needed, monthly weights were to be obtained, and the nutritional plan of care was to be continued. A CAR note dated 1/15/25 indicated, Resident 1's weight was down to 205 pounds. The Registered Dietician (RD) wrote a note which indicated, "...obtain reweight to verify weight loss from 231 to 205 lbs. New scale being used this month, which may be more accurate. No weight x 60 days...." A CAR note dated 1/24/25 indicated the identical information from 1/15/25, "...obtain reweight to verify weight loss from 231 to 205 lbs. New scale being used this month, which may be more accurate. No weight x 60 days...." A CAR note dated 1/31/25 indicated the identical information from 1/15/25 and 1/24/25, "...obtain reweight to verify weight loss from 231 to 205 lbs. New scale being used this month, which may be more accurate. No weight x 60 days...." A CAR note dated 2/7/24 indicated the identical information from the three previous notes, "...obtain reweight to verify weight loss from 231 to 205 lbs. New scale being used this month, which may be more accurate. No weight x 60 days...." Resident 1 had a comprehensive care plan, dated 8/11/23 and revised 8/7/24, which indicated he had nutritional problems related to his diagnoses and his weights fluctuated with the use of a diuretic. Intervetnions included, but were not limited to, RD to evaluate and make diet change		2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - Residents have the potential to be affected by the alleged deficient practice. Current in-house residents were audited on 02/19/25 by the DON for nutritional status. None noted during this time. No further actions are required. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DON and ADON were educated with concentration on, but not limited to, Envive Nutritional Policy. - Education and training were provided to DON and ADON on 2/6/25 by the clinical support consultant. Education provided: Envive Nutritional Policy p paraid="298928192"	

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	recommendations as needed, weight as ordered. Resident 1's vital records for weight logs were reviewed and revealed he refused to be weighed on multiple occasions. The residents record lacked documentation that the weight discrepancy had been assessed by the Dietician The residents record lacked documentation the physician was notified of the weight loss and no additional supplements were added. The residents record lacked documentation of new care plan interventions to address his weight loss, or that he often refused to be weighed. On 2/14/25 at 2:00 p.m. the Administrator (ADM) provided a copy of a current facility policy titled, "Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol," dated 8/2024. The policy indicated, " ... 4. The staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake ...." 3.1-22(a)		paraeid="{ca696aa7-bb65-46ef-bf61-29004dec1df0}{171}" > 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DON/designee will complete daily monitoring to ensure residents accurate and appropriate nutritional assessments are completed and will be reviewed in clinical care meeting the following weekday for accuracy 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. DON/designee will be responsible for monitoring compliance for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. ¿ The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	

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			5. Date of completion: 03/24/2025	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis Based on record review and interview, the facility failed to complete pre and post dialysis assessments for a resident that received dialysis from an outside facility for 1 of 1 resident reviewed (Resident 79). Findings include: On 2/6/25 at 2:15 p.m. Resident 79's medical record was reviewed. She was a long-term care resident with diagnoses which incuded, but were not limited to, diabetes mellitus type 2, heart failure, end stage renal disease (ESRD), muscle weakness, and anxiety disorder. Resident 79's Pre-Dialysis assessments were reviewed and lacked documetation that assessments had been completed on the following dates: 1/27/25, 1/24/25, 1/13/25, 1/8/25, 1/6/25, 1/3/25, 1/1/25, 12/30/24, 12/27/24, 12/25/24, 12/23/24, 12/18/24, 12/16/24, 12/11/24, 12/9/24, 12/6/24, 12/4/24, 12/2/24, 11/27/24, 11/20/24, and 11/11/24. Resident 79's Post-Dialysis assessments were reviewed and lacked documetation that assessments had been completed on the following dates: 1/22/25, 1/17/25, 1/13/25, 1/8/25, 1/6/25, 1/3/25, 1/1/25, 12/30/24, 12/27/24, 12/25/24, 12/23/24, 12/18/24, 12/16/24, 12/11/24, 12/9/24, 12/6/24, 12/4/24, 12/2/24, 11/29/24, 11/27/24, 11/25/24, 11/20/24, 11/18/24, and 11/11/24.	F 0698	**F698 – Dialysis** *"Facility failed to to complete pre and post dialysis assessments for a resident that received dialysis from an outside facility for 1 of 1 resident reviewed (Resident 79)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 79 was affected by the alleged deficient practice. Resident 79 immediately had alleged deficient practice corrected by completing a pre- and post-dialysis assessment. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All dialysis residents have the potential to be affected by the alleged deficient practice. All current in-house residents were audited on 02/6/25 by the DON for dialysis pre- and post-dialysis assessment completion. All dialysis residents	03/24/2025

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	A comprehensive care plan, dated 7/31/24, indicated Residnet 79 required hemodialysis due to ESRD. She had an intervention indicating she would have no complications from dialysis and appropriate assessments would be completed before and after her return from the Dialysis center. During an interview on 2/6/25 at 2:30 p.m., the Vice President of Clinical Services (VPCS) provided paperwork from the Dialysis center which had not been obtained until request, and lacked documentation in the residents's medical record. The VPCS indicated Pre/Post assessments completed by the facility staff could not be located. A policy titled, "Dialysis Monitoring," dated 11/22, was provided by the VPCS on 2/12/25 at 12:25 p.m. It indicated, " ...Obtain vital signs (blood pressure and pulse) at a minimum following dialysis treatment. Assessment of the fistula site for presence or absence of bruit and thrill every shift. Assessment of the dialysis catheter site for any signs of drainage and condition of the dressing to the site. Document and notify the physician of any signs or symptoms of complications observed during assessment such as bleeding, swelling, infection, redness, warmth, etc ...." 3.1-37(a)		are up-to-date- with pre-and post dialysis assessments. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON and ADON were educated with concentration on, but not limited to, Envive End-Stage Renal Disease, Care of a Resident with Policy. - Education and training were provided to DON and ADON on 2/7/25 by the clinical support consultant. Education provided: Envive End-Stage Renal Disease, Care of a Resident with Policy **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** DON/SSD/designee will complete daily monitoring through audits to ensure that any resident for dialysis assessment completion for 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. DON/SSD/designee will be responsible for the monitoring compliance of the for 6 months. The results of these audits will be	

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			reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 03/24/2025	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to date medications with time limitations and failed to remove medications from use when they expired for 2 of 3 medication rooms reviewed and 4 of 7 medication carts reviewed. Findings include: On 2/10/25 at 10:42 a.m., the A wing medication room was observed. A bottle of tubersol was inside the refrigerator and it lacked a date to indicate when it was opened. The A wing front cart had an insulin pen, lantus, with a date opened of 1/10/25 belonging to Resident 99. The B wing front cart had an insulin pen that lacked a date to indicate when it was opened belonging to Resident 7. The B wing back cart had a vial of amikacin that was opened and lacked a date to indicate when it	F 0761	p paraid="1275318555" paraeid="{ca696aa7-bb65-46ef-bf61-29004dec1df0}{221}" >F761 – Label/Store Drugs and Biologicals “Facility failed to date medications with time limitations and failed to remove medications from use when they expired for 2 of 3 medication rooms reviewed and 4 of 7 medication carts reviewed.” 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice.	03/24/2025

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	was opened belonging to Resident 29. Licensed Practical Nurse (LPN) 11 indicated she just opened the vial that morning. A policy titled, "Medication Labeling and Storage," was provided by the Director of Nursing (DON) on 2/12/25 at 1:26 p.m. It indicated, " ...Mult-dose vials that have been opened or accessed (e.g. needle punctured) are dated and discarded within 28 days unless the manufacturer specified a shorter or longer date for the open vial ...." 3.1-25(j) 3.1-25(m) 3.1-24(n)		Medication carts and medication rooms were immediately inspected for mislabeled or expired medications. None were identified. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - Residents receiving medications have the potential to be affected by the alleged deficient practice. Medication carts and medications rooms were audited on 02/10/25 by the DON for mislabeled or expired medications. None noted during this time. No further actions were required. p paraid="1643485879" paraeid="{03b05c32-294d-41f7-83a6-eabbc0cb476d}{54}" >3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DON and ADON were educated with concentration on, but not limited to, Envive Medication	

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			Labeling and Storage Policy. - Education and training provided to DON and ADON on 2/10/25 by the clinical support consultant. - Education and training provided to licensed clinical staff on 3/13/25 Education provided: Envive Medication Labeling and Storage Policy. 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DON/designee will be responsible for weekly monitoring to ensure medication carts and medications rooms remain free from mislabeled or expired medications and will be reviewed in clinical care meeting the following weekday for accuracy weekly for 8 weeks then monthly in QAPI for 6 months. DON/designee will be responsible for monitoring compliance for 6 months. The results of these audits will be reviewed by the QA committee overseen by the	

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			Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. ¿ The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. 5. Date of completion: 03/24/2025	
F 0838 SS=F Bldg. 00	483.70(e)(1)-(3) Facility Assessment Based on observation, interview, and record review, the facility failed to ensure the Facility Assessment Tool was updated in a timely manner to reflect the specific nursing needs, care and treatments services for the identified resident population. This deficient practice had the potential to affect 102 of 102 residents who resided in and received nursing care, services and treatments in the facility. Findings include: The Facility Assessment Tool is used to identify, quantify, and outline the resident population in order to effectively provide materials, equipment, care and services in order to attain or maintain the highest practicable physical, mental and psychosocial well-being of the residents who reside in the facility.	F 0838	p paraid="1918639308" paraeid="{03b05c32-294d-41f7-83a6-eabbc0cb476d}{172}" >F838 – Facility Assessment “Facility failed to ensure the Facility Assessment Tool was updated in a timely manner to reflect the specific nursing needs, care and treatments services for the identified resident population. This deficient practice had the potential to affect 102 of 102 residents who resided in and received nursing care, services and treatments in the facility.”	03/24/2025

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	During the survey entrance conference on 2/6/25 at 10:06 a.m., a copy of the facility's Assessment Tool was requested and provided by the Administrator (ADM). On 2/6/24 at 11:07 a.m., the ADM provided a Facility Assessment, dated November 2023, which reflected data and assessment for the year 2023. On 2/14/25 at 1:00 p.m., the most recent Facility Assessment tool, reflective of the year 2024 was requested. On 2/14/25 at 1:15 p.m., the ADM provided a Facility Assessment dated for November 2024, but the information was identical. During an interview on 2/14/25 at 1:22 p.m., the ADM indicated, he used the previous 2023 as a template and updated the date, therefore the data might not be a direct reflect of the current population and resident needs. The following discrepancies were reviewed with the Administrator: In general, the facility's average daily census ranged from 105-115. Common diagnoses of the resident population included, but were not limited to, psychosis, impaired cognition, mental disorder, depression, bipolar disorder, schizophrenia, post-traumatic stress disorder and anxiety. a. The Facility Assessment tool used the Resource Utilization Group (RUG) Version IV, (which is a system used to classify long-term care residents into groups based on their care needs,) to identify the acuity of care required based on population averages. One area of identified acuity needs was for "Behavioral Symptoms and		1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice. p paraid="706962714" paraeid="{03b05c32-294d-41f7-83a6-eabbc0cb476d}{204}" >2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. No residents were affected by the alleged deficient practice. Facility Assessments were updated to comply with requirement. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Administrator educated by VP of Special Projects on Envive Facility Assessment Policy. - Education and training were	

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	Cognitive Performance," which was quantified as, "6." However, the facility identified "Special Treatment and Conditions" which included, but was not limited to "Mental Health," listed "0" active or current substance use disorders, and "Behavioral Health Needs," was left blank. b. The Facility Assessment Tool Part 2: "Services and Care we Offer Based on our Resident Needs," indicated, " ...Mental Health and Behavior-Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities ..." However the Facility Assessment did not document or specify who the Psychiatric provider was. How often they were available to the residents, or how/who determined a residents needs for psychiatric services and what provisions would/could be made if the provider was unavailable. c. The Facility Assessment Tool Part 3: "Facility Resources Needed to Provide Competent Support and Care for Our Resident Population Every Day and During Emergencies," identified the following types of staff members and/or other health professionals needed to care for the residents, (included, but not limited to) Behavioral and mental health providers, but again, lacked specification/identification of those staff members designated and or other contracted rounding		provided to Administrator on 2/18/25 by the VP of Special Projects Education provided: Envive Facility Assessment Policy. 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? ED/designee will monitor to ensure the facility assessment is accurate and up-to-date monthly for 6 months. ED/designee will be responsible for monitoring compliance for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. ¿ The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	

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	providers. It lacked specification of how often these staff members would be available to the residents and to what degree of serves could/should be provided. In order to provide person-centered/directed care: Psycho/social/spiritual support the Facility Assessment indicated, " ...identify hazards and risks for residents ..." However during the QAPI interview, identification of cited concerns related to infection control practices and accident hazards related to resident's smoking procedures had not been identified and/or discussed. Cross Reference F880 and F689.		5. Date of completion: 03/24/2025	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on observation, interview, and record review, the facility failed to maintain complete and accurate medical records for 1 of 1 residents (Resident 3) reviewed for medical record accuracy. Findings include: On 2/6/25 at 10:46 a.m., Resident 3 was observed in her room yelling out nonsensical things at anyone who walked by her room. On 2/6/25 at 11:30 a.m., Qualified Medication Aide (QMA) 5 indicated Resident 3 was usually out at the nurses' station because she would often get lonely. On 2/11/25 at 2:42 p.m., Resident 3's medical record was reviewed. She was a long-term care resident whose diagnoses included but were not limited to, schizoaffective disorder (a mental health condition that combines symptoms of	F 0842	p paraid="1548793712" paraeid="{a530a295-e68a-426d-9949-e8fe08beba12}{113}" >F842 – Resident Records – Identifiable Information “Facility failed to maintain complete and accurate medical records for 1 of 1 (Resident 3) reviewed for medical record accuracy.” 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 3 was affected by the	03/24/2025

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	schizophrenia and a mood disorder), unsteadiness on feet, and difficulty in walking. An Interdisciplinary Team (IDT) note, dated 1/8/25 at 10:00 a.m., indicated Resident 3 had a fall on 1/7/25. The intervention for this fall was to implement 15-minute safety checks for 72 hours to reduce falls and increase resident safety. A nursing progress note, dated 1/8/25 at 7:20 p.m., indicated the resident had a fall. On 2/14/25 at 10:45 p.m. the Vice President of Clinical Services indicated they could not provide documentation proving 15-minute safety checks were completed for 72 hours for Resident 3. On 2/14/25 at 2:00 p.m. the administrator provided a copy of a current facility policy titled, "Falls and Fall Risk Management," dated 8/2024. The policy indicated " ... The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling ...". 3.1-13(u) 3.1-13(v)		alleged deficient practice. Resident 3 immediately had alleged deficient practice corrected by having medical record reviewed for accuracy. Corrections and/or modifications were made as appropriate. 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. - Residents have the potential to be affected by the alleged deficient practice. Current in-house residents were audited on 02/17/25 by for medical record accuracy. None noted during this time. No further actions are required. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? DON and ADON were educated with concentration on, but not limited to, Envive Electronic Medical Records Policy. - Education and training	

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			provided to DON and ADON on 2/17/25 by the clinical support consultant. - Education and training provided to licenses clinical staff on 3/13/25 by the DON Education provided: Envive Electronic Medical Records p paraid="1146711640" paraeid="{e10a70c8-f95d-4639-bfaa-3502cda54e6f}{6}" >4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DON/designee will complete weekly monitoring to ensure residents accurate and appropriate medical records are completed and will be reviewed in clinical care meeting the following weekday for accuracy 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. DON/designee will be responsible	

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			for monitoring compliance for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. ¿ The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. 5. Date of completion: 03/24/2025	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observations, interviews and record review, the facility failed to ensure staff who were symptomatic with illness were tested and/or wore source control to prevent the potential for spreading infection throughout the community, and the facility failed to ensure staff donned personal protective gear, (PPE) while providing high-contact resident care to those residents who required enhanced barrier precautions (EBP) in order to protect them from the potential of infection, and failed to ensure PPE was readily available outside and/or just inside of the resident's rooms who required EBP. This deficient practice had the potential to affect 11 of 102 resident who required EBP.	F 0880	p paraid="88621591" paraeid="{e10a70c8-f95d-4639-bfaa-3502cda54e6f}{62}" >F880 – Infection Prevention & Control “Facility failed to ensure staff who were symptomatic with illness were tested and/or wore source control to prevent the potential for spreading infection throughout the community, and the facility failed to ensure staff donned personal protective gear, (PPE) while providing high-contact resident care to those residents who	03/24/2025

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	Findings include: 1a. On 2/6/25 shortly after the conclusion of the exit conference, the former Regional Nurse Consultant (RNC) arrived onsite. She apologized for being late, she indicated she did not feel well. Her voice was hoarse, she sniffled and had a rattling cough. She indicated she had not tested for illness, but thought it was just a cold. She intended to stay to help on survey. On 2/7/25 at 9:27 a.m., the former RNC was observed as she wiped down and cleaned out a medication cart in the secured memory care unit. The RNC had a rattling cough and runny nose. She coughed and sniffled repeatedly. She sneezed into her elbow several times. She was not observed to wear a mask. During an interview on 2/7/25 at 9:30 a.m., the RNC indicated, she didn't feel well, "I'm sick," she did not know what she had, but it must be whatever was "going around." During an interview on 2/10/25 at 9:06 a.m., the Memory Care Coordinator (MCC) indicated, she did not feel well that morning, but felt better than she had over the weekend. She spent the weekend in bed sick and had experienced chills and diarrhea. She indicated, because she did not have a fever she decided to come into work. She indicated she had not taken any tests to rule out Covid and/or flu, because it was probably whatever was going around. She was not observed to wear a mask throughout the survey period. On 2/10/25 at 9:46 a.m., the Cooperate Business Office Manager (CBOM) was observed as she coughed several times. Her voice was hoarse as		required enhanced barrier precautions (EBP) in order to protect them from the potential of infection, and failed to ensure PPE was readily available outside and/or just inside of the resident's rooms who required EBP. This deficient practice had the potential to affect 11 of 102 resident who required EBP." 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 11 residents were potentially affected by the alleged deficient practice. Residents immediately had alleged deficient practice corrected by assessing the 11 residents for appropriate available PPE. All PPE stocked at this time. Staff immediately had alleged deficient practice corrected by assessing the need for further intervention related to signs and symptoms of illness. No further action needed at this time. 2: How other residents having the potential to be affected by the	

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	she indicated, she was getting over a bought of bacterial pneumonia. She was not observed to wear a mask throughout the survey period. During an interview on 2/10/25 at 9:47 a.m., with the CBOM present, the Director of Nursing Services (DNS) indicated, she still did not feel well and was still getting over an illness. She was not observed to wear a mask throughout the survey period. During a random observation on 2/10/25 at 11:18 a.m., the MCC spoke with Resident 97. She did not perform hand hygiene before she shook his hand and patted his cheek, then did not perform hand hygiene as she continued to assist other residents with room trays. On 2/10/25 at 10:32 a.m., the Vice President of Clinical Services (VPCS) provided a copy of current facility policy titled, "Coronavirus Disease (Covid-19) - Work Restrictions and Return to Worl Criteria for Staff," revised 8/2024. The VPCS indicated, although the policy specifically mentioned Covid-19, it was applicable for other highly contagious illnesses as well. The policy indicated, "Staff who have symptoms of Covid-19 [and/or other highly contagious illness'] or have tested positive for [Covid-19] infection follow CDC guidelines and facility policy for work restrictions and return-to-work-criteria ... staff will follow all recommended infection prevention and control practices, including wearing a well-fitted source control, monitoring themselves for fever or symptoms consistent with Covid-19, and not reporting to work when ill or it testing positively for Covid-19 infection .... If symptoms recur ... these staff will be restricted from work and follow recommended practices to prevent transmission to others (e.g. use of well-fitting source control) until		same deficient practice will be identified and what corrective action will be taken. - Residents needing PPE have the potential to be affected by the alleged deficient practice. Staff with signs and symptoms of illness have the potential to be affected by alleged deficient practice. ul class="BulletListStyle1 SCXW71311189 BCX8" role="list" style="-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; margin: 0px; padding: 0px; user-select: text; cursor: text; font-family: verdana; overflow: visible;" Current in-house residents needing PPE were audited on 02/19/25 by the DON for PPE supplies. PPE stations restocked at this time. No further actions were required. Staff within the building were assessed for signs and symptoms of illness and appropriate action taken. No further action at this time. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?	

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	155077	A. BUILDING 00 B. WING	02/14/2025

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	they again meet criteria to return to work unless an alternative diagnosis is identified. 1b. On 2/7/25 at 10:30 a.m., Resident B was observed from the hallway, through her open door, she was in bed on her left side, faced away from the door, and her privacy curtain was not closed. Registered Nurse (RN) 6 stood at the right side of her bed, and Certified Nursing Adie (CNA) 22 was on the left side of her bed. Neither nursing staff was observed to EBP PPE. CNA 22 was observed as she removed a brief from under the resident, rolled it up and placed it in a trash bag. RN 6 stepped toward the head of the resident's bed, so that her bare bottom and several wounds of varying conditions were visible from the hallway. RN 6 continued to provide wound care treatment. On 2/11/25 at 10:14 a.m., Resident B's door was knocked on with no answer. She was briefly observed through the cracked door, with RN 9 and CNA 23 present, when RN 9 indicated, "patient care." Neither nursing staff member had on PPE. During an interview on 2/11/25 at 10:28 a.m., RN 9 indicated, she did not know if Resident B still required EBP or not. There was a sign on her door, but there had not been any PPE outside of any of the resident's rooms for a long time. On 2/13/25 at 1:35 p.m., Resident B's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, a history of necrotizing fasciitis, (a rare but life-threatening bacterial infection that rapidly destroys the soft tissues and fascia (connective tissue) beneath the		DON and ADON educated with concentration on, but not limited to, Envive Equipment and Supplies Used During Isolation Policy and Envive Healthcare-Associated Infections, Identifying Policy - Education and training provided to DON and ADON on 2/17/25 by the clinical support consultant. - Education and training provided to clinical staff on 3/13/25 by DON Education provided: Envive Equipment and Supplies Used During Isolation Policy Envive Healthcare-Associated Infections, Identifying Policy 4: How be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? DON/designee will complete weekly monitoring to ensure residents PPE stations are stocked and personnel is donning/doffing appropriately and staff is being monitored for signs and symptoms of illness weekday 5 days a week for 4 weeks, 3	

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	skin), open pressure and arterial wounds, colostomy status, and requirement of an indwelling catheter for neurogenic bladder. Resident B had a comprehensive care plan dated 10/9/24 which indicated, she required the use of Enhanced Barrier Precautions related to her chronic wounds, indwelling medical devices (an enteral tube and indwelling urinary catheter) to reduce the risk of transmission of multi-drug-resistant organisms (MDROs). Interventions for this plan of care included, but were not limited to, ensure PPE is available, follow CDC guidelines for EBP when performing the following high-contact resident care activities ... providing hygiene, changing briefs and wound care ... precautions should be in place until discontinuation of the indwelling medical devise ... precautions should be in place until resolution of the wound(s) .... 2. On 2/6/25 at 10:46 a.m. the room of Resident 1 was observed. Resident 1's room did not have an Enhanced Barrier Precaution sign on the door and there was no Personal Protective Equipment (PPE) available. Resident 1 had multiple pressure injuries which require the use of EBP. On 2/6/25 at 10:50 a.m. the room of Resident 90 was observed. Resident 90's room did not have an EBP sign on the door and there was no PPE available. Resident 90 had a gastrointestinal tube which requires the use of EBP. On 2/7/25 11:15 a.m. The Regional Nurse Consultant was observed as she cleaned the medication carts out. At the time she was not wearing a face mask, and she was coughing and sneezing regularly.3. On 2/11/25 at 2:55 p.m., Resident D's wounds were observed with Licensed Practical Nurse (LPN) 11 and Certified		days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. DON/designee will be responsible for monitoring compliance for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. ¿ The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. 5. Date of completion: 03/24/2025	

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	Nursing Assistant (CNA) 16 present. CNA 16 turned Resident D to his side, while LPN 11 removed dressings from Resident's sacrum. LPN 11 and CNA 16 did not wear PPE during the procedure. There was an orange sign in the top right corer of his door which indicated he was in EBP. On 2/13/24 at 11:39 a.m., Resident D was observed. CNA 16 was in his room and assisted Resident D, as he prepared for a shower. CNA 16 did not don PPE. Throughout the survey week, no PPE was observed to be avilable inside or outside of Resident D's room. On 2/11/25 at 11:28 a.m., Resident D's medical record was reviewed. He was a long-term care resident with diangoses which inclucded, but were not limited to, neuromusculare dysfunction of the bladder which required the use of in indwelling urinary catheter, and chronic wounds. He had current physician's which included, but were not limited to, EBP related to his wounds and the use of a urinary catheter. His Comprehenisve Care Plans were reviewed, and included, but were not limite to, a care plan which indicated he required EBP until his wounds resolved and his indwelling medical device was discontinued. A policy titled "Enhanced Barrier Precautions" dated 8/24 was provided by the Vice President of Clinical Services (VPCS) on 2/7/25 at 1:00 p.m. It indicated, " ...EBPs are utilized to prevent the			

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	spread of multi-drug-resistant organisms (MRDOs) to residents. PPE is available outside of the residents' rooms ....". This deficiency relates to Complaint IN00452206. 3.1-18(a)			
F 9999 Bldg. 00	3.1-13 ADMINISTRATION AND MANAGEMENT (w) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of	F 9999	p paraid="197849647" paraeid="{5ce9574b-cb40-4735-9d99-da8e6ff8935f}{91}" >F9999 – FINAL OBSERVATIONS – Administration and Management “Facility failed to ensure an Alzheimer's/Dementia Special Care Disclosure Form was completed and submitted as required annually in December. This deficient practice had the potential to effect 26 of 26 residents who resided on the secured memory care unit.” 1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice.	03/24/2025

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	care for residents with dementia. (x) The director of the Alzheimer's and dementia special care unit shall do the following: (1) Oversee the operation of the unit. (2) Ensure that: (A) personnel assigned to the unit receive required in-service training; and (B) care provided to Alzheimer's and dementia care unit residents is consistent with: (i) in-service training; (ii) current Alzheimer's and dementia care practices; and (iii) regulatory standards. This state rule was not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a Alzheimer's/Dementia Special Care Disclosure Form was completed and submitted as required annually in December. This deficient practice had the potential to effect 26 of 26 residents who resided on the secured memory care unit. Findings include: During the survey entrance conference on 2/6/25 at 10:06 a.m., the Executive Director (ED) indicated, the facility did have a specialized, secured memory care unit (MC) which was opened in the middle of October, beginning of November of 2024, therefore, a copy of the most recent Alzheimer's/Dementia Special Care Disclosure Form was requested. On 2/6/25 at 10:35 a.m.., an initial tour of the Secured Special Memory Care unit was conducted. There were 26 residents who resided in the unit and were engaged in various independent activities.		2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. p paraid="1711019900" paraeid="{5ce9574b-cb40-4735-9d99-da8e6ff8935f}{129}" > - 26 residents had the potential to be affected by the alleged deficient practice. /Dementia Special Care Disclosure Form was completed and submitted as required. 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Administrator was educated with concentration on, but not limited to, Alzheimer’s/Dementia Special Care Disclosure Form and timeline for submission. Education and to Administrator on 2/17/25 by the VP of Special Projects 4: How be monitored to ensure the deficient practice will not recur	

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	During the facility exit conference on 2/14/25 at 2:45 p.m., the Dementia Disclosure form had not submitted but would be provided by the end of the business day. On 2/14/25 at 3:46 p.m., a copy of the Dementia Disclosure form was provided. The form was dated 2/14/25 even though it gave instructions which indicated, "please complete on or before December 31st. Data must be current as of December 1st." The Disclosure form indicated the Alzheimer's/Dementia care program differed from other programs and units of the facility, but did not details how as indicated. Continuing education for the memory care unit was left blank. 3.1-13(w)		i.e., what quality assurance program will be put into place? ED/designee will monitor to ensure the Alzheimer's/Dementia Special Care Disclosure Form assessment is accurate and up-to-date monthly for 6 months. ED/designee will be responsible for monitoring compliance for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. ¿ The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. 5. Date of completion: 03/24/2025	