STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 00 B. WING	06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00408400. Complaint IN00408400 - State Residential deficiencies related to the allegations are cited at R0239. Survey dates: June 5, 6, 7, 8, 9 and 12, 2023. Facility number: 001156 Provider number: 155505 AIM number: 100453350 Census Bed Type: SNF/NF: 13 SNF: 15 NF: 17 Total: 45 Census Payor Type: Medicare: 15 Medicaid: 17 Other: 13 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 22, 2023.	F 0000	Please accept the following plan of correction as credible evidence of compliance to the deficiencies cited during our recent Annual Survey at Robin Run Village. Hopefully, you will find our remedies to be both sufficient and thoroughly explained. The Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. We are requesting Paper Compliance Review with the submission of these remedies. If after reviewing the plan of correction you have any questions, please do not hesitate to contact us.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Newcomer	Executive Director	07/11/2023

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	accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to ensure a soft touch call light (an assistive device used to summon staff for residents with limited mobility) was in reach for a resident for 1 of 15 residents reviewed for call light use (Resident 57). Findings include: On the following dates and times Resident 57's soft touch call light was observed on the upper right corner of the bed on his non-functional side of his body where he was unable to reach it: 6/5/23 at 12:08 p.m., 6/6/23 at 10:10 a.m., 6/7/23 at 12:10 p.m., 6/8/23 at 11:50 a.m., and 6/9/23 at 1:26 p.m. On 6/7/23 at 1:25 p.m., Resident 57's record was reviewed. He had diagnoses which included, but were not limited to, incomplete quadriplegia (the paralysis of all four limbs blocks some, but not all signals from getting through, the person might still have some ability to move), displaced fracture of the second cervical vertebra (neck spinal bones), fracture of T7-8 vertebra (chest spinal bones), Parkinson's disease (progressive disease of the nervous system), and muscle weakness. A comprehensive care plan, dated 2/16/23, indicated Resident 57 had an activity of daily living (ADL) self-care deficit for bed mobility, transfers, eating, and toileting due to his limited mobility related to his diagnosis of cervical vertebral fracture. An intervention for this plan of care included, but was not limited to, staff encouragement for Resident 57 to use the "special	F 0558	F558 Accommodation of needs/preferences 1. Corrective action for residents identified: a. Resident #57 will be re-evaluated for the blow call light by nursing and/or therapy. b. Nursing staff will be re-educated on placement of Res #57s call light on left side for access. c. Res #57 plan of care will be updated and communicated to nursing staff as indicated. 2. All in house residents are at risk for the alleged deficient practice. No other in-house residents are indicated for using blow call light. 3. Measures put into place and or systemic changes to ensure alleged deficient practice does not recur: a. Nursing staff will receive education regarding placement of call lights and or special devices for call light by the DON and or designee, b. Nursing staff will receive education regarding placement of call lights and or special devices for call light by the DON and or designee, during orientation and as indicated. 4. Monitoring to ensure and	07/26/2023

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	blow call light to call for assistance." The care plan was updated on 6/7/23 and indicated "the resident requests the call light be placed low by his left arm or on his abdomen." A comprehensive care plan, dated 2/16/23, indicated Resident 57 was at risk for falls related to gait/balance problems related to his diagnosis of cervical vertebral fracture. An intervention for this plan of care included but was not limited to staff were to "make sure" Resident 57's "special blow touch call light was within reach and encourage" Resident 57 "to use it for assistance as needed." Resident 57 "needs prompt response to all requests for assistance." During an interview on 6/8/23 at 11:45 a.m., Certified Nursing Aide (CNA) 18 indicated Resident 57 could use his soft touch call light. He had used it that morning, but it was laying on his abdomen then. She tried to move the call light back to his right side by his shoulder, but the Resident indicated he wanted it on his left side by his (functional) left hand/arm. During an interview on 6/8/23 at 3:39 p.m., the Director of Nursing (DON) indicated Resident 57 was able to push a call light. During an interview on 6/8/23 at 3:40 p.m., the Vice President of Clinical and Regulatory Compliance (VPCRC) indicated Resident 57's call light should have been wherever he could have used it. On 6/7/23 at 11:25 a.m., the VPCRC provided a copy of current facility policy titled, "Answering the Call Light." The policy indicated, "...be sure the call light is within easy reach of the resident ...."		quality assurance to ensure alleged deficient practice does not recur: a. DON and or designee will audit call light placement 3x weekly x4 weeks, then weekly x4 weeks then monthly x1 to ensure call light placement and or call light devices are in place to be used. b. Re-education of staff will be conducted as indicated, ongoing. c. Audits will be reviewed during quality assurance meetings, at least monthly by the QA committee. The QA committee will determine if audits need to continue or plan to be updated as indicated.	

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F 0641 SS=A Bldg. 00	3.1-3(v)(1) 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure residents' Minimum Data Set (MDS) assessments were coded accurately to reflect their most current medical/health conditions for 3 of 15 residents reviewed for MDS accuracy. Findings include: 1a. On 6/7/23 at 10:13 a.m., Resident 3's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, schizoaffective disorder, vascular dementia, major depressive disorder and generalized anxiety. She had physician's orders which included, but were not limited to; a. prazosin, for her schizoaffective disorder. (Prazosin is a medication used to manage several conditions and can cause unusual tiredness or weakness). b. escitalopram, for her major depressive disorder. (Escitalopram is an antidepressant medication that can also cause tiredness and weakness). c. haloperidol, for her schizoaffective disorder. (Also known as Haldol, an antipsychotic medication that can cause dry mouth or increase salivation).	F 0641	F656 Comprehensive Care Plans: 1. Corrective action for residents identified: a. Res #59 will have care plan updated to include advanced directives and risk for dehydration and include fluid preferences. 2. In house residents are at risk to ensure advanced directives and, if indicated, risks for dehydration for interventions and preferences. a. A review of inhouse residents will be completed by the DON/designee to ensure a care plan is in place for residents' preferences regarding advanced directives and, if indicated, those at risk for dehydration will have care plans updated to reflect fluid preferences. 3. Measures put into place and or systemic changes to ensure alleged deficient practice does not recur: a. Nursing staff, MDS Coordinator and Interdisciplinary Team (IDT) will receive education regarding care plan policy and regulatory requirements for developing and implementing resident-centered approaches to care planning by the Regional	07/26/2023

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	d. buspirone, for her anxiety. (Also known as Buspar, an antianxiety medication that can cause dizziness and drowsiness). e. trazadone, for her major depressive disorder. (Trazadone, is an antidepressant medication that can cause drowsiness and dry mouth). A nursing progress note, dated, 3/25/23 at 7:33 p.m., indicated, Resident 3 had an unwitnessed fall. She indicated she attempted to get up while eating her food, "also mentioned about choking on her food trying to get up and fell on the floor." She sustained a broken nose and was sent to the Emergency Room (ER) for further evaluation and treatment. A corresponding hospital record, dated 3/26/23, indicated Resident 3 admitted after a fall at her Extended Care Facility (ECF) and sustained a facture of her nasal bone. The most recent comprehensive MDS assessment was an annual assessment dated 5/3/23. Section J, Health Conditions did not indicate Resident 3 had sustained a fall with a major injury since the previous assessment. 1b. Resident 3 had a Pre-Admission Screen and Resident Review (PASRR) Level I, dated 5/26/22, which required level II follow up. On 6/7/23 at 3:07 p.m., the Assistant Director of Nursing (ADON) provided a copy of Resident 3's Level II which was reviewed at that time. The Level II was dated 5/5/22 and indicated Resident 3 was considered to have a serious mental illness and was approved for long-term		Nurse/designee. b. During the morning clinical quality assurance (QA) meeting and weekly Risk IDT QA meeting, the IDT will review new/readmissions, new or changed orders to ensure a resident centered approach is care planned for advanced directives and risk for dehydration per resident preferences. c. Nursing staff will be educated regarding resident-centered care plan and resident preferences regarding advanced directives and risk for dehydration fluid preferences. This education will be provided by the DON/designee for compliance, orientation and as indicated. 4. Monitoring to ensure and quality assurance to ensure alleged deficient practice does not recur: a. DON/designee will complete audits of care plans and observations to ensure care plans are resident-centered regarding advanced directives, risk for dehydration and interventions implemented per preferences. b. Audits will be reviewed during the weekly Risk meeting QA and monthly QA for compliance weekly x8 weeks. The QA committee will determine if audits need to continue or plan to be updated as indicated. 5. Date of compliance: 7.26.23	

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	care without specialized services. The most recent comprehensive MDS assessment was an annual assessment dated 5/3/23. Section A, Identification Information did not indicate Resident 3 was considered by the state to have a serious mental health illness. During an interview on 6/8/23 at 2:31 p.m., the Vice President of Regulatory Compliance (VPRC) reviewed the MDS discrepancies and indicated they were coded incorrectly. 2. On 6/8/23 at 10:05 a.m., Resident 59's medical record was reviewed. She had diagnoses which included, but were not limited to, cerebral palsy (a disorder that affects the ability to maintain posture), muscle weakness, dysphagia (difficulty swallowing), altered mental status, and age-related physical debility. The record lacked documentation that Resident 59's weight had been recorded upon her admission on 3/21/23. The record contained a weight for May that was 121.1 pounds. The record lacked documentation of a weight for March and April. Her most recent MDS was dated 3/28/23 and indicated Resident 59 had a weight of 121 pounds. A Care Area Assessment (CAA) worksheet indicated the weight on the MDS was taken from the hospital records prior to admission to the facility. The MDS Coordinator did not include a date to indicate when the resident was in the hospital. A comprehensive care plan, dated 3/30/23,			

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	indicated Resident 59 had a nutritional problem or potential nutritional problem related to diet restrictions, puree nectar thickened liquid (NTL) and due to diagnosis of dysphagia. An intervention, dated 3/30/23, instructed staff to monitor, record and report to the physician as needed for signs and symptoms of malnutrition: emaciation (cachexia), muscle wasting, significant weight loss: 3 pounds in 1 week, 5% in a month, 7.5% in 3 months and 10% in 6 months. Another intervention, dated 3/30/23, indicated staff should weigh the resident at the same time of the day and record. During an interview on 6/8/23 at 10:56 a.m., the DON indicated residents should be weighed upon admission and then once a week for 4 weeks. After that, residents should be weighed at least monthly. 3. On 6/9/23 at 9:35 a.m., Resident 47's medical record was reviewed. She was a long-term care resident who had diagnoses which included, but were not limited to, Parkinson's disease (a degenerative disease affecting the muscles and brain), muscle weakness, and dysphagia. Her most recent MDS was dated 3/6/23 which included her height, but no weight was recorded. The MDS indicated the resident had experienced weight loss. Resident 47's last weight, recorded prior to 3/6/23 had been on 1/26/23 and she weighed 111.5 pounds. A comprehensive care plan, dated 2/2/23, indicated, the Resident had an unplanned/unexpected weight loss related to poor food intake. An intervention included, but was			

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	not limited to, ensure staff weighed the resident at the same time of the day and record frequency, time and scale. During an interview on 6/8/23 at 10:56 a.m., the VPRC indicated she was aware of the missing weight on the MDS and it should have been coded.			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.			

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	(iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observations, interviews and record review, the facility failed to ensure comprehensive care plans were created and implemented for 1 of 15 residents reviewed for care plan implementation (Resident 59). Findings include: During an observation on 6/6/23 at 9:49 a.m., Resident 59 had 2 cups of water on her overbed table. The cups had lids on them with no straws to access the water without taking the lids off. The water was warm. She indicated she liked cold water with ice. During an observation on 6/8/23 at 9:40 a.m., Resident 59 had a cup of water on her overbed table. The cup had a lid with a straw inserted into the lid. The straw contained half of the wrapper still on it. The water was warm.	F 0656	F656 Comprehensive Care Plans: 1. Corrective action for residents identified: a. In house residents are at risk to ensure care plans for advanced directives according to preferences are implemented on the care plan b. In house residents at risk for dehydration are at risk to ensure care plans updated to include interventions and preferences. 2. In house residents are at risk to ensure advanced directives and, if indicated, risks for dehydration for interventions and preferences. a. A review of inhouse residents will be completed by the DON/designee to ensure a care	07/26/2023

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	On 6/8/23 at 10:05 a.m., Resident 59's medical record was reviewed. She had diagnoses which included, but were not limited to, cerebral palsy (a disorder that affects the ability to maintain posture), muscle weakness, dysphagia (difficulty swallowing), altered mental status, and age-related physical debility. The most recent Minimum Data Set (MDS) assessment was dated 3/28/23. It included a Care Area Assessment (CAA) worksheet which indicated Resident 59 was at risk for dehydration related to a urinary tract infection, (UTI). Resident 59 had a physician's order dated 3/22/23 for her advanced directive preferences. The order indicated to provide cardiopulmonary resuscitation, (CPR). Resident 59's comprehensive care plans were reviewed and lacked documentation that a plan of care had been created for her risk of dehydration and advance directive preferences. On 6/7/23 at 11:37 a.m., the VPRC provided a copy of current facility policy titled, "Care Plan, Comprehensive Person-Centered." The policy indicated, "...The comprehensive, person-centered care plan: includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including, services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment, and which professional services are responsible for each element of care, includes the resident's stated goals upon admission and desired outcomes, builds on the resident's		plan is in place for residents' preferences regarding advanced directives and, if indicated, those at risk for dehydration will have care plans updated to reflect preferences. 3. Measures put into place and or systemic changes to ensure alleged deficient practice does not recur: a. Nursing staff, MDS Coordinator and Interdisciplinary Team (IDT) will receive education regarding care plan policy and regulatory requirements for developing and implementing resident-centered approaches to care planning by the Regional Nurse/designee. b. During the morning clinical quality assurance (QA) meeting and weekly Risk IDT QA meeting, the IDT will review new/readmissions, new or changed orders to ensure a resident centered approach is care planned for advanced directives and risk for dehydration per resident preferences. c. Nursing staff will be educated regarding resident-centered care plan and resident preferences regarding advanced directives and risk for dehydration fluid preferences. This education will be provided by the DON/designee for compliance, orientation and as indicated. 4. Monitoring to ensure and quality assurance to ensure	

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	strengths and reflects currently recognized standards of practice for the problem areas and conditions ...." 3.1-35(a)		alleged deficient practice does not recur: a. DON/designee will complete audits of care plans and observations to ensure care plans are resident-centered regarding advanced directives, risk for dehydration and interventions implemented per preferences. b. Audits will be reviewed during the weekly Risk meeting QA and monthly QA for compliance weekly x8 weeks. The QA committee will determine if audits need to continue or plan to be updated as indicated.	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident			

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	representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview, and record review, the facility failed to ensure comprehensive care plans were revised to update person-centered interventions for 7 of 15 residents reviewed for care plan revision and timing, (Residents 14, 3, 26, 46, 47, 59 and 1). Findings include: 1. On 6/5/23 at 11:00 a.m., Resident 14's medical record was reviewed and indicated she had been transferred to the hospital on 3/24/23. She returned 3/29/23 after surgery to repair a fractured femur. On 6/7/23 at 8:47 a.m., Resident 14 was observed in a seated position in her bed with a tray table and breakfast plate. When asked if she had any recent falls, Resident 14 indicated yes. When asked if that was how she fractured her femur, Resident 14 indicated, "well that's a mystery." She indicated she did not fall, and although she did not remember the day it happened she was told by her daughter and staff that she had been acting out of her ordinary and was in her wheelchair going up and down the halls, which she never did. Resident 14 indicated she had a very routine schedule and preferred to stay in her room. During an interview on 6/7/23 at 1:20 p.m.,	F 0657	F657 Care Plan Timing and Revision 1. Corrective action for residents identified: a. Res #14 will have care plan reviewed by the IDT for history of UTI's and signs and symptoms and current transfer status, b. Res #3 will have care plan reviewed by the IDT and updated with interventions placed for the fall on 3.25.23, c. Res #26 will have care plan reviewed by the IDT and updated with interventions placed for the fall on 5.23.23 which was determined to be an isolated incident, d. Res #46 will have care plan reviewed by the IDT and updated with interventions placed for the fall on 3.30.23, e. Res #47 will have care plan updated to appropriate level of care; i.e., long-term care by the DON/designee, f. Res #59 will have care plan updated for diet and thickened liquids per physician's orders by DON/designee,	07/26/2023

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	Resident 14's daughter indicated her mother had sustained a serious femur fracture, but no one seemed to know how or when. Her mother had a history of urinary tract infections (UTIs), and she would always become delirious, which led to several falls when she was in Assisted Living. Since being in Long Term Care (LTC) she had continued to have UTIs with delirium. On 3/24/23 Resident 14's daughter had been in to visit and was very concerned at the intensity of her delirium. She was up in her wheelchair, which she typically never used, and was roaming up and down the halls talking about needing to go somewhere, she was late for an appointment, or she talked about children being around. She shuffled her feet back and forth to move her wheelchair up and down the halls. She had started an antibiotic a few days prior for a UTI, but her symptoms did not seem to be getting better, so she spoke with the doctor about her mother's condition. On 6/7/23 at 9:02 a.m., Resident 14's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, age related osteoporosis, unsteadiness on feet, and muscle weakness. On 3/31/23 a diagnosis of fracture of the lower end of the left femur was added. She had recurrent UTIS as evidence by: a. A nursing progress note, dated, 10/25/22 at 5:55 p.m., indicated, new verbal order to send out due to new onset of hallucinations and delusions. On 10/26/23 at 7:01 a.m., she returned from the hospital with a diagnosis of a UTI and a new order for Cephalexin (an antibiotic medication) 500 mg (milligrams).		g. Res #1 will have care plan reviewed and updated by the DON/designee to include Passive Range of Motion (PROM) exercises as indicated. 2. Residents at risk: a. In house residents with falls and updated interventions post fall, UTIs, PROM exercises, diets including thickened liquids, changes in level of care from assisted living to long-term care, and fall interventions post fall are at risk; residents identified with these areas will have their care plan updated as indicated by the DON/designee and IDT. 3. Measures put into place and or systemic changes to ensure alleged deficient practice does not recur: a. MDS Coordinator and Interdisciplinary Team (IDT) will receive education regarding care plan policy and regulatory requirements for care plan revisions and updates, after each MDS assessment including comprehensive and quarterly and updates as indicated by the Regional Nurse/designee. b. During the morning clinical quality assurance (QA) meeting and weekly Risk IDT QA meeting, the IDT will review new/readmissions, new or changed orders, interventions to ensure care plans are updated to reflect the current status of the resident for updated interventions	

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	b. A nursing progress note, dated, 3/8/23 at 8:11 a.m., indicated, Resident 14 continued to have increased confusion. She refused to take her medication, made delusional statements and was agitated. New verbal orders were received to obtain labs. On 3/8/23 at 12:01 p.m., indicated, Resident 14's daughter came to visit due to her mental status and wanted her treated right away and new verbal order was given to start Keflex (an antibiotic medication) 500 mg (milligrams) three times a day for 5 days. c. A nursing progress note, dated, 3/21/23 at 8:24 p.m., urine specimen obtained and placed in fridge for pick up in morning. Antibiotics started per order. A corresponding physician's order, dated, 3/21/23 was started for Keflex 500 mg four times a day. A nursing progress note, dated, 3/24/23 at 6:30 p.m., indicated the nurse was called to Resident 14's room by a Certified Nursing Aide (CNA) to look at her leg. The resident's foot was cold to the touch, dusky and there was a slight internal rotation. Her upper thigh was edematous (Swelling caused by excess fluid in body tissues) and hard. The nurse was unable to palpate a pedal pulse on her left foot. A call was placed to her daughter and received confirmation that she wanted the resident sent out to the hospital. Resident 14's comprehensive care plans were reviewed and found to lack documentation of implementation and/or revision to address her history of UTIs and symptoms of her UTI which included delirium. Resident 14's comprehensive care plans lacked revision of her transfer status to total assist with a Hoyer.		post fall, UTIs, PROM exercises, diets including thickened liquids, changes in level of care from assisted living to long-term care. 4. Monitoring to ensure and quality assurance to ensure alleged deficient practice does not recur: a. DON/designee will complete audits of care plans and observations to ensure care plans for new/readmissions, new or changed orders, interventions to ensure care plans are updated to reflect the current status of the resident for updated interventions post fall, UTIs, PROM exercises, diets including thickened liquids, changes in level of care from assisted living to long-term care. b. Audits will be reviewed during the weekly Risk meeting QA and monthly QA for compliance weekly x8 weeks. The QA committee will determine if audits need to continue or plan to be updated as indicated	

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	2. On 6/6/23 at 8:57 a.m., Resident 3 was observed in her room. She was lying on her bed, diagonally rather than horizontally. A breakfast tray was on her bedside table and 100% had been consumed. There were food crumbs on the floor under the table. On 6/7/23 at 10:08 a.m., Resident 3 was observed. She appeared to be asleep in her bed. On 6/7/23 at 10:37 a.m., Resident 3 was observed. She sat on the edge of her bed. 100% of her breakfast appeared to have been eaten, and there were food crumbs on the floor at her feet. At that time, she indicated she had a fall in her room after she thought she was choking on some food, and when she stood up to cough, slipped on some food on the floor. She fell forward and hit her face on the floor which broke her nose. On 6/7/23 at 10:13 a.m., Resident 3's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, schizoaffective disorder, vascular dementia, major depressive disorder and generalized anxiety. A nursing progress note, dated, 3/25/23 at 7:33 p.m., indicated, Resident 3 had an unwitnessed fall. She indicated she attempted to get up while eating her food, "also mentioned about choking on her food trying to get up and fell on the floor." She sustained a broken nose and was sent to the Emergency Room (ER) for further evaluation and treatment. Resident 3 had a comprehensive care plan initiated 2/5/21 which indicated she was at risk for falls. Although the care plan focus was revised on			

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	3/27/23 to include the description of the above fall, there were no new interventions put in place to address the root cause of her fall which resulted in a fracture. 3. On 6/5/23 at 2:27 p.m., Resident 26 was observed. She was seated in an electric wheelchair. She indicated she liked to go to the Assisted Living (AL) and Independent Living side for activities and had even led some activities as the Resident Council President. On a recent visit, she had gone over in her electric wheelchair she fell out of the wheelchair when she went off the curb. She did not sustain any injuries. On 6/7/23 at 10:54 a.m., Resident 26's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, end stage renal disease, contracture of her right and left knee. An Interdisciplinary Team (IDT) post fall evaluation, dated, 5/23/23 at 12:15 p.m., indicated, an activities aid witnessed the fall. "Reason for the fall was evident, Resident did not use the wheelchair ramp and rolled over the curb," however, further in the IDT eval, it indicated, "wheelchair was no involved in the fall." She gave vocal complaints of pain in her left buttock. Actioned clinical suggestions was left blank, and no new interventions were put in place. A nursing progress note, dated 5/23/23 at 2:34 p.m., indicated, Resident 26 had a fall on the Independent Living side at 12:00 p.m. Resident did not use the wheelchair ramp and instead, rolled over the curb. Resident 26 had a comprehensive care plan initiated 10/25/18 which indicated she was at risk			

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	for falls related to her weakens. Although the focused was revised to describe the fall from 5/26/23 and indicated Occupational Therapy (OT) was to evaluate for safety awareness, no new intervention was added. 4. On 6/6/23 at 2:09 p.m., Resident 46's medical record was reviewed. He was a long-term care resident with diagnoses which included, but were not limited to, Parkinson's disease and a history of falling. A nursing progress note, dated, 3/30/23 at 12:02 p.m., indicated, Resident 46 had an unwitnessed fall while he tried to transfer from the bed to the wheelchair. He had no notes injuries at that time. The record lacked documentation of an IDT post fall follow up. Resident 46 had a comprehensive care plan initiated 8/29/22 which indicated he was at risk for falls due to unsteady gait and balance. The care plan lacked revision to include new interventions after his 3/30/23 fall. During an interview on 6/8/23 at 2:31 p.m., The Vice President of Regulatory Compliance, indicated, when a resident had a fall, it was expected that there would be an IDT fall follow up and new interventions put into place to address the root cause of the fall to prevent further falls.5. On 6/9/23 at 9:35 a.m. Resident 47's medical record was reviewed. She had diagnoses which included, but were not limited to, Parkinson's disease, pressure ulcer of sacral region, muscle weakness, and dysphagia (difficulty swallowing). Prior to her admission to the healthcare facility, she had been treated in the hospital for a urinary			

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	tract infection (UTI). Her comprehensive care plans were reviewed, and indicated she was still a resident of the Assisted Living facility. The care plan lacked revision to change her residency to the long-term care setting. 6. On 6/8/23 at 10:05 a.m., Resident 59's medical record was reviewed. She had diagnoses which included, but were not limited to, diagnoses, but not limited to, cerebral palsy, muscle weakness, and dysphagia (trouble swallowing). Her current physician's order was for a regular diet. A comprehensive care plan dated 3/30/23 indicated, Resident 59 consumed a nectar thickened liquids (NTL) and a pureed diet. The care plan lacked revision that her diet had been upgraded to a regular diet. 7. On 6/6/23 at 10:26 a.m., Resident 1's medical record was reviewed. Resident 1's diagnoses included, but were not limited to, diagnoses, type 1 diabetes mellitus (a blood sugar disorder), hemiplegia (muscle weakness or paralysis) on his right side and a cerebral infarction (stroke). Although a comprehensive care plan, dated 5/29/18, indicated, Resident 1 had an alteration in musculoskeletal status due to multiple contractures, the care plan lacked revision to include passive range of motion services. During an interview on 6/7/23 at 2:45 p.m., the Vice			

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	President of Regulatory Compliance (VPRC) and Director of Nursing (DON), and Assistant Director of Nursing (ADON), were present. Concerns related to care plan revision and timing were reviewed and discussed. The DON concurred that the above discussed care plans lacked appropriate revisions. A policy titled, "Care Plan, Comprehensive Person-Centered," was provided by the VPCO on 6/7/23 at 11:37 a.m. It indicated, " ...The comprehensive, person-centered care plan: includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including, services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment, and which professional services are responsible for each element of care, includes the resident's stated goals upon admission and desired outcomes, builds on the resident's strengths and reflects currently recognized standards of practice for the problem areas and conditions ...." 3.1-35(c)(1)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure appropriate nail care was completed for residents' who could not do nail care for themselves for 3 of 3 residents	F 0677	F677 ADL Car Dependent Residents 1. Corrective action for residents identified:	07/26/2023

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	reviewed for nail care (Residents 59, 21, and 23). Findings include: 1. During an observation on 6/6/23 at 9:49 a.m., Resident 59 had a dark brown substance under her fingernails, along with facial hair on her chin. She indicated she would like to have the hair removed from her chin. During an observation on 6/7/23 at 10:36 a.m., Resident 59 had a dark brown substance under her fingernails. During an observation on 6/8/23 at 9:37 a.m., Resident 59 had a dark brown substance under her fingernails. A record review was completed on 6/8/23 at 10:05 a.m. Resident 59 had the following diagnoses, but not limited to cerebral palsy, muscle weakness, dysphagia, altered mental status, hypothyroidism, hyperlipidemia, major depression, essential hypertension, gastro-esophageal reflux disease, and age-related physical debility. Resident 59's care plan, dated 3/24/23, indicated she had an ADL (Activities of Daily Living) self-care performance deficit for bed mobility, transfers, eating, and toileting related to limited mobility due to a diagnosis of UTI (Urinary Tract Infection). An intervention, dated 3/24/23, indicated Resident 59 required extensive assistance of one person with personal hygiene and oral care. During an interview on 6/8/23 at 2:00 p.m., the Director of Nursing (DON) indicated Resident 59 allowed staff to trim and clean her fingernails. Resident 59 refused personal care at times.		a. Res #59 received nail care and chin hair care during survey by nursing staff. Res #59 care plan will be updated by the DON/designee for refusal of ADL cares, b. Res #21 received nail care during survey by nursing staff. DON/designee will meet with Hospice regarding nail care during their visits and care plan updated as indicated, c. Res #23 received nail care during survey by nursing staff. Res #23 is offered utensils to eat with but often times will use fingers to eat chocolate pudding. Care plan will be updated to reflect intolerance to nail care at times. 2. In house, dependent residents requiring assistance with nail care; cleaning and trimming and removal of facial hair unless refuse are at risk: a. A review of dependent residents for nail care; cleaning and trimming and removal of facial hair will be completed by the DON/designee. Residents identified with needing nail care and or facial hair removal will receive by nursing staff, b. Care plans of dependent resident preferences, refusals of cares regarding nail care and facial hair removal will be updated by the DON/designee. 3. Measures put into place and or systemic changes to ensure alleged deficient practice	

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	Resident 59's record lacked a care plan addressing refusal of care. 2. During an observation on 6/7/23 at 11:07 a.m., Resident 21's fingers were observed to be clinched. She would not open her hands. Chipped purple nail polish was on her fingernails. She had a dark brown substance under her nails. During an observation on 6/8/23 at 12:02 p.m., Resident 21's fingers were clinched. Chipped purple nail polish was on her fingernails. She had a dark brown substance packed under her fingernails. On 6/8/23 at 1:45 p.m., a record review was completed. She had the following diagnoses, but not limited to unspecified dementia, major depressive disorder, hypothyroidism, essential hypertension, emotional lability, anxiety disorder, hyperlipidemia, tremor, restlessness and agitation and Alzheimer's disease. A review of Resident 21's shower sheets was completed. The record lacked documentation she received nail care on her shower days. Resident 21 had a care plan problem, dated 10/21/21, indicated she had a ADL (Activity of Daily Living) self-care performance deficit for bathing, toileting, eating, transfers and bed mobility related to dementia and tremors at times. An intervention, dated 10/21/21, indicated she was totally dependent on one staff for personal care and oral care. During an interview with the scheduling coordinator and hospice nurse, they indicated she received nail care and would make certain that she		does not recur: a. Nursing staff will receive education regarding ADL nail care and facial hair removal during bathing and as needed. Residents refusing per preference to have nail care and or facial hair removal, will be documented in the clinical record and or bath sheets by the charge nurse. b. Refusals of nail care and or facial hair removal will be reviewed in the morning clinical meeting by the IDT and attempts to complete tasks will be re-evaluated by the DON/designee. 4. Monitoring to ensure and quality assurance to ensure alleged deficient practice does not recur: a. DON and or designee will audit nail care and chin hair care and documentation ADL nail care and facial hair removal during bathing and as needed. Residents refusing per preference to have nail care and or facial hair removal, will be documented in the clinical record and or bath sheets by the charge nurse 3x weekly x4 weeks, then weekly x4 weeks then monthly x1 to ensure nail care and chin hair care is being provided according to the plan of care and for each dependent resident. b. Re-education of nursing staff, regarding the above, will be conducted as indicated, ongoing. c. Audits will be reviewed	

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	received nail care during hospice visits for the resident. During an observation with the VPCO (Vice President of Clinical Operations) on 6/9/23 at 10:20 a.m., Resident 21 was holding a baby doll. Her fingers were wrapped around the baby doll's arms. Her fingers and hands were not clinched. The VPCO indicated the facility did not have a policy for nail care. 3. On 6/5/23 at 1:58 p.m., Certified Nursing Aide (CNA) 12 was observed sitting in the unoccupied portion of Resident 23's room. She indicated she was watching over Resident 23 and had been there about 40 minutes. Resident 23 was observed at that time. She had dried remnants of chocolate pudding circumferential (all the way around) around her mouth, on both hands, and under her fingernails. Her fingernails were noted to be long and unevenly cut, some had been broken. She indicated she ate some of the pudding with her hands. Thick chocolate pudding was dried under her fingernails. On 6/5/23 at 2:05 p.m., CNA 12 brought in a wet washcloth and asked the resident to wipe her hands. The resident wiped at her hands but was unable to get the thick, dried pudding off her hand and under her nails. Then, CNA 12 used the same washcloth her wipe the dried chocolate pudding from around Resident 23's mouth. On 6/6/23 at 9:22 a.m.., Resident 23's was observed with dried chocolate pudding on her hands and under her fingernails. On 6/6/23 at 9:36 a.m., Registered Nurse (RN) 6, indicated she would get someone to clean Resident 23's hands and fingernails. On 6/6/23 at 9:38 a.m., Resident 23 was observed		during quality assurance meetings, at least monthly by the QA committee x2 months. The QA committee will determine if audits need to continue or plan to be updated as indicated.	

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	scratching at her left shoulder with uneven fingernails on her left hand. On 6/6/23 at 10:02 a.m., the Assistant Director of Nursing (ADON) was observed trying to get Resident 23 to put her fingernails in an emesis basin of water to hydrate the chocolate pudding for easier removal. She used an orange stick (used to clean under fingernails) to try and remove the chocolate pudding. On 6/6/23 at 10:06 a.m., Resident 23 asked the ADON to stop because it was hurting her. A care plan, dated 7/14/22, indicated Resident 23 had an ADL (activities of daily living) self-care performance deficit for bed mobility, transfers, eating, and toileting related to dementia. Her interventions were to check nail length and trim and clean on bath day and as necessary, to report any changes to the nurse and the resident required extensive staff assistance with personal hygiene. On 6/8/23 at 3:34 p.m., the Vice President of Clinical and Regulatory Compliance (VPCRC) indicated Resident 23 ate her food with her fingers. On 6/8/23 at 3:37 p.m., the Assistant Director of Nursing (ADON) indicated she saw the resident long, uneven fingernails. She had to soak the fingernails to get the dried pudding off the them. A current policy, titled, "Fingernails/Toenails, Care of," dated October 2010, was provided by the VPCRC, on 6/8/23 at 10:00 a.m. A review of the policy indicated, " ...The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection ...Nail care			

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	includes daily cleaning and regular trimming ...Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin ...." 3.1-38(a)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure resident dressing changes were completed appropriately for 1 of 2 residents reviewed for dressing changes, a resident's skin assessments were completed and accurate for 1 of 3 residents reviewed for skin assessments, and failed to float a resident's heels according to a physician's order for 1 of 3 residents observed for skin assessments (Resident 23). Findings include: On 6/6/23 at 3:10 p.m., Resident 23's record was reviewed. Her diagnoses included but were not limited to, diabetes mellitus (DM), heart failure, anxiety disorder, dementia (progressive brain disorder), history of malignant neoplasm (cancer) of the bladder, and an artificial open of urinary tract (urostomy).	F 0684	F684 Quality of Care 1. Corrective action for residents identified: a. Res #23 as of 7.5.23 areas of incontinent dermatitis on coccyx remains clear as well as bilateral shoulders, abrasion left lateral knee continues to progress. Wound treatment was changed 6.7.23 to include dry dressing instead of foam. Measurements are located for weekly follow up in the wound assessment tool. Res #23 will continue to be followed by wound nurse practitioner and attending physician. Res #23 currently has a low air loss mattress and will continue to have heels floated with heel boots or pillows as the resident allows. Plan of care will	07/26/2023

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	1. Resident 23's Weekly Skin Integrity Reviews were reviewed. a. On 5/5/23, a pressure ulcer on the coccyx was noted with no measurements. b. On 5/12/23, incontinent associated dermatitis on the coccyx was noted with no measurements. c. On 5/19/23, incontinent associate dermatitis on the coccyx was noted to be red, an abrasion to the right front knee, and right shoulder (rear) was an abrasion from the resident scratching, No measurements for these wounds. d. On 5/26/23, incontinent associate dermatitis on the coccyx was noted, right knee (front), Right shoulder (rear) and left shoulder (rear) were noted with no descriptions. No measurements for these wounds. e. On 5/31/23, an abrasion on the left knee measuring 5.8 cm x 2.3 cm, and left shoulder scratches. f. On 6/2/23, left shoulder abrasion was noted with no description. A skin care plan, revised on 5/19/23, indicated the resident had potential/actual impairment to skin integrity. The interventions included, but were not limited to, avoid scratching and keep hands and body parts from excessive moisture; keep Resident 23's fingernails short; monitor and document the location, size and treatment of skin injuries; report abnormalities, failure to heal, signs and symptoms of infection, maceration (breakdown of skin) to her physician; and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. A nursing progress note, dated 6/6/2023 at 11:54 a.m., indicated Resident 23 had excoriation to her bilateral buttocks with shearing areas noted to		be updated as indicated by the DON/designee. 2. in house residents with wounds and wound dressings are at risk for weekly measurements of wounds and foam dressings being applied correctly. Residents with wounds were reviewed by wound nurse/designee during survey and no other residents were identified with unmeasured wounds or foam dressings not applied correctly. 3. Measures put into place and or systemic changes to ensure alleged deficient practice does not recur: a. Licensed nurses will be provided education by the DON/wound nurse/designee regarding correct application of foam dressings and measurements of newly identified or worsening wounds if noted during treatments in the nurse's notes or the weekly skin assessment for compliance, and importance of floating heel(s) if indicated in the plan of care for compliance, during orientation and as indicated. b. Established wounds are documented weekly including measurements in the wound observation tool by the wound care nurse/designee. c. DON/designee will review documentation during the morning clinical meeting to ensure measurements were documented	

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	both buttocks. New order received for Triad to area every shift. On 6/6/23 at 2:48 p.m., the Wound Nurse (WN) 7 indicated the wound on Resident 23's left knee was not an abrasion. On 6/5/23 at 2:10 p.m., a physician's order, dated 6/2/23, indicated for the left knee: use wound cleanser, xeroform to the wound, and a foam dressing, to change 3 times per week. On 6/6/23 at 1:58 p.m., Registered Nurse (RN) 6 was observed to rinse her hands in the resident's sink, turned off the faucet with her bare hands, dried them with paper towels. RN 6 put on disposable gloves. For the treatment for both the upper and lower left lateral (outside) knee wounds, she used wound cleanser on a 4 x 4 gauze and wiped the wounds from the center to the outside edges. She did not pat the wounds. The lower left lateral wound had 100% granulation. She described the wounds as red with scant drainage due to cleansing the wound. She indicated the edges were approximated (the wound edge fit together snugly) with 100% epithelial tissue (the final stages of healing). She removed her gloves, used hand sanitizer on her hands, and put on clean gloves. The wound edges were observed not to be approximated and the wound did not have 100% epithelial tissue. The upper left lateral wound was 10-15% slough (dead tissue) with little to no drainage. It had a scab in middle. The edges were intact. Several scabs were noted on left leg.		in the clinical record. 4. Monitoring to ensure and quality assurance to ensure alleged deficient practice does not recur: a. DON/designee will review newly identified or declining wounds to ensure measurements have been documented in the clinical record; in addition will audit foam wound care dressings are applied correctly and heel(s) floated if indicated 3x/wk x4 weeks, weekly x4 weeks then monthly x1. b. Audits will be reviewed during the weekly Risk meeting QA and monthly QA for compliance weekly x8 weeks. The QA committee will determine if audits need to continue or plan to be updated as indicated. 5.	

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	On 6/6/23 at 2:11 p.m., RN 6 indicated hand washing was not possible in the resident's bathroom because the water flow was too low. On 6/6/23 at 2:15 p.m., RN 6 folded a large xeroform dressing (occlusive dressing) in half and placed a bordered foam dressing over it. The bordered foam dressing did not seal around the edges because the xeroform dressing was sticking out beyond the wounds and bordered foam dressing (island dressing to seal and protect the wound). She dated and initialed the dressing. On 6/6/23 at 2:33 p.m., RN 6 indicated the xeroform dressing should have been completely enclosed under the bordered foam dressing. The bordered foam dressing should have had sealed edges to the skin. On 6/6/23 at 2:21 p.m., Resident 23 was turned on her side. Her disposable brief was soiled. RN 6 cleaned up the resident, removed her gloves, and used hand sanitizer. Excoriation was observed on the sacral area. The Regional Consultant (RC) 19 indicated she had shearing to her right and left buttocks. RN 6 applied Triad paste. The resident was observed to have long scabbed scratch marks on the lateral hip and slightly posterior buttocks. On 6/6/23 at 2:26 p.m., RN 6 indicated the resident sacral area was excoriated above the buttocks, shearing and the discolored area around rest of bottom, she was unable to define. She indicated the wound had an arrhythmia (condition where the heart beats in an irregular or abnormal rhythm). On 6/6/23 at 2:28 p.m., the Regional Consultant asked RN 6 if she meant to said erythema (superficial reddening of the skin).			

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On 6/6/23 at 2:29 p.m., RN 6 removed her gloves, used hand sanitizer, and put on clean gloves. She placed a clean disposable brief on Resident 23.

A current policy, titled, "Wound Care," dated October 2010, was provided by the VPCRC, on 6/8/23 at 10:00 a.m. A review of the policy indicated, " ...Arrange the supplies so they can be easily reached. Wash and dry your hands thoroughly ...Loosen tape and remove the dressing. Wash and dry your hands thoroughly ...Wear sterile gloves when physically touching the wound or holding a moist surface over the wound ...."

2. On 6/7/23 at 9:35 a.m., the ADON provided the most recent podiatry note. It indicated Resident 23 was seen on 4/6/23. Her toenails were elongated, discolored, mycotic (disease called by fungus), and thick with subungual debris. Her toenails were debrided according to the resident's tolerance. He was able to reduce length and thickness to 2 mm. To recall him as medically necessary, but no sooner than 60 days. There was no note indicating a scab on her right foot, third toe.

On 6/5/23 at 2:10 p.m., Resident 23's feet were observed. Her toenails were long and yellowish. The right foot, third toe had a scab on the toenail itself.

A physician's progress notes for an acute visit, on 6/6/23 at 8:00 a.m., indicated Resident 23 had a toe lesion, one-half the size of a dime on the third toes of her right foot.

On 6/6/23 at 2:17 p.m., Registered Nurse (RN) 6 indicated the facility did not have any treatments

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	for her toe. On 6/6/23 at 2:18 p.m., RN 19 touched the scab on the toenail with her gloved hand. Resident 23 indicated that the toe hurt. On 6/6/23 at 2:38 p.m., RN 6 indicated the right foot, third toe scab had been there for a while. A current physician's order, dated 6/6/23, indicated to place Silvadene cream on outer left leg wound for one week and cover with a dry dressing. For the right foot, third toe, betadine solution twice a day for 7 days, leave open to air. On 6/8/23 at 11:15 a.m., the right foot, third toe scab was observed. A small part of the scab was missing showing redness underneath. 3. On 6/5/23, during an observation, from 1:58 to 2:16 p.m., Resident 23's heels were observed not floated, but lying on the bed. On 6/8/23 at 11:15 a.m., Resident 23's heels were observed resting on a towel with the pillow under knees. An active physician's order, started on 9/29/22, indicated to float heels every shift. On 6/8/23 at 11:21 a.m., the Assistant Director of Nursing (ADON) was observed to remove a towel under Resident 23's heel. She indicated her heels should not have been resting on the towel. She moved the pillow from under her knees and placed it under her calves to float her heels. 3.1-40(a)(3) 3.1-3(a)			

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to identify the potential for accidents when a mobility aid was removed from a bed, leaving the open attachment bar exposed next to the mattress for 1 of 6 residents reviewed for accidents (Resident 20). Findings include: During an observation on 6/5/23 at 11:03 a.m., Resident 20 was observed sitting in her wheelchair next to her bed. A circular grab bar (called a Halo device) was observed installed on the open side of her bed. She indicated she had falls in the past and a Halo bar was placed to both sides of her bed. She indicated the Halos on both sides had been helpful, but "some lady" came in and took the right Halo off her bed. Resident 20 indicated this had made bed mobility more difficult for her. She was less mobile in bed and her sense of security on the right side of the bed was no longer present. During an observation on 6/6/23 at 9:45 a.m., Resident 20 was observed sitting in her room. She had a Halo on the left side of her bed. During an observation on 6/7/23 at 1:13 p.m.,	F 0689	F686 Accident Hazards/Supervision/Devices 1. Res #20 has both the mobility bars attached for bed mobility. Res #20 had no injuries noted from the bed mobility holders. Res #20 plan of care will be updated as indicated. 2. In House residents, not using the bed mobility aid bars, will have the mobility aid holders removed by maintenance. 3. Systems and or changes to ensure practice does not recur: a. Mobility bars will be reviewed by the IDT to determine if bed mobility bars are needed for bed mobility during the MDS/RAI process. b. Mobility bars not being used for bed mobility will be removed as well as the holders to the bed frame. c. Maintenance and nursing will be provided education in regard to bed mobility aid holders being removed due to safety unless residents are using the bed	07/26/2023

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	Resident 20's bed had a halo on the left side. There was no Halo on the right side of the bed. During an interview on 6/7/23 with the Vice President of Regulatory Compliance (VPRC) and the Director of Nursing (DON) present, they indicated they did not know who removed the Halo and would further investigate the reason for the removal of the Halo. On 6/8/23 at 11:03 a.m., Resident 20's medical record was reviewed. She had diagnoses which included, but were not limited to, schizoaffective disorder, (a severe mental illness) type 2 diabetes mellitus (a blood sugar disorder), restless leg syndrome, insomnia, and anxiety. A physician's order, dated 4/22/23, indicated for Resident 20 required bilateral mobility bars to assist with transfers and mobility. A comprehensive care plan, dated 6/17/21, indicated Resident 20 had an activities of daily living (ADL) self-care performance deficit related to limited mobility. An intervention in place for this plan of care indicated Resident 20 used bi-lateral Halo devises to maximize independence with bed mobility and positioning. During an interview on 6/8/23 at 2:45 p.m., the VPRC indicated she could not find any documentation related to the removal of the Halo. They were going to put the halo back on the bed and a restraint assessment had been completed to demonstrate that the Halos were not restraints. A policy titled, "Assistive Devices and Equipment" was provided by the VPRC on 6/8/23 at 10:00 a.m., it indicated, " ...Certain devices and equipment that assist resident with mobility,		mobility aids by the DON/designee. 4. Monitoring to ensure practice does not recur: a. DON/designee will audit bed mobility aids weekly x4 weeks to ensure they are removed from beds that do not have the mobility bars in use or are in place for those residents able to use them as indicated. b. Audits will be reviewed at least monthly by the QA committee x2 months. The QA committee will determine if audits need to continue or plan to be updated as indicated.	

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	safety, and independence are provided for residents. These may include but are not limited to specialized eating utensils and equipment, safety devices for the bathroom (grab bars, toilet riser's bedside commodes) and mobility devices (wheelchairs, walker and canes). Recommendation for the use of devices is based on the comprehensive assessment and documented in the resident care plan ...." 3.1-45(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview and record review, the facility failed to monitor a resident, who experienced a change of condition due to weight loss, and failed to ensure interventions	F 0692	F692 Nutrition/Hydration Status 1. Res #47 has been reviewed for weight loss by the IDT, RD and physician. Res #47 has been	07/26/2023

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	were implemented to prevent further weight loss and decline for 1 of 2 residents reviewed for weight loss (Resident 47). Findings include: During an observation and interview on 6/8/23, Resident 47 was sitting in her recliner. The leg rest was up. She was attempted to demonstrate how to lower her legs but was unable to as she was observed to press the cloth side of the chair, and not the retract button. When asked about the food, Resident 47 indicated it was horrible and she did not like it. During an observation on 6//8/23 at 2:35 p.m., Resident 47 was sitting in her wheelchair in her room. During an observation on 6/9/23 at 1:02 p.m., Resident 47 was sitting in the dining room. She was eating a turkey wrap sandwich. She was able to feed herself. A record review was completed on 6/9/23 at 9:35 a.m. She had diagnoses which included, but were not limited to, Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), a pressure ulcer of sacral region, muscle weakness, dysphagia (difficulty swallowing), and difficulty in walking and age-related physical debility. On 12/5/22, she weighed 135 pounds. In January she was weighed at 112 pounds, which was a 23-pound weight loss in the span of 1 month. She had not been weighted in February. By 3/9/23, she had lost and additional 13 pounds and was down to 99 pounds.		getting weekly weights since March 2023 to monitor weight loss, supplement since February 2023 and followed by the Registered Dietician. 7.6.23 social services director placed a call to responsible party to discuss weight loss intervention and alternatives. Res #47 will have a significant MDS completed by the MDSC and plan of care will be reviewed by the IDT and updated as indicated for significant weight loss. 2. Residents with significant weight loss are at risk to ensure interventions implemented to prevent further weight loss. A review of residents with significant weight loss will be reviewed by the DON/designee to ensure interventions are implemented to prevent further weight loss and comprehensive MDS completed if indicated by the MDSC. 3. Systems or changes to ensure the practice does not recur: a. Residents with significant weight loss will be reviewed weekly by the IDT in Risk. Interventions will be implemented to prevent further loss to the extent possible and documented in the clinical record; this includes eating assistive devices. b. Assistive devices will be included on each resident's tray/meal card if indicated for dietary department to add to meal	

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	progress note, dated 2/2/23, from the RD (Registered Dietician) indicated ST (Speech Therapy) upgraded her diet to aid with intakes (meal consumption) due to resident requiring increased nutritional needs related to a pressure injury to her sacrum. The RD requested to add a multivitamin, med pass, an appetite stimulant, and weekly weights to monitor a pattern. Resident 47 received a new order on 2/17/23 for Centrum Silver (a multivitamin) daily as a supplement. Med pass 2.0 was added 2/16/23. An appetite stimulant was not added as recommended. On 2/16/23, a progress note indicated the family requested her food to be cut up for ease of eating. Her care plan was reviewed and lacked revision to include this intervention. A progress notes dated 3/9/23 from the RD indicated there was no weight for Resident's current MDS (Minimum Data Set). Her weight loss was 11.2% loss in 30 days and 22.5% in 180 days. She documented resident was using a divided plate with plate rim, and a 1 handled cup to increase independence with self-feeding and drinking and to continue discussion for an appetite stimulant. She indicated resident was at increased risk for further weight loss and artificial support should be considered if desired. On 3/29/23, a new order was received for staff to obtain weekly weights. Her diet order was for a regular diet with med pass 2.0 (a nutritional supplement) 120 milliliters (ml) three times daily.		service. c. Residents with significant weight loss will be evaluated by the MDSC and comprehensive MDS completed if indicated. 4. Monitoring to ensure practice does not recur: a. DON/designee will audit residents with significant weight loss and those with eating devices, and comprehensive MDS completed by the MDSC if indicated 3x weekly x4 weeks, then weekly x4 weeks then monthly x1 to ensure residents with significant weight loss have eating adaptive equipment if indicated. b. DON/designee will monitor weekly IDT notes for residents with significant weight loss to ensure monitoring is documented.	

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	On 3/7/23, a new order was received to change her diet to lactose free, due to diarrhea, however her current diet order did not include a lactose free diet. She had orders to go to the dining room for meals, and to use a divided plate with a rim and one handled cups for drinks to increase independence with self-feeding and drinking. The physician signed an unavoidable weight loss assessment on 6/5/23. Prior to this date, the record lacked documentation of the physician following Resident 47 for weight loss. She was not observed to utilize a divided plate with rim or a 1 handled cup during the survey. Further, her care plan was reviewed and lacked revision to include this intervention. A progress note dated 5/30/23 from the RD indicated resident had a pressure ulcer to her coccyx, and no new recommendations were made. Upon review, Resident 47 was noted to have 2 areas of decline for the Assessment Reference Date, (ARD) for her minimum data set (MDS) assessment. She had both developed a new wound and experienced a significant weight loss. A care plan dated 2/2/23 indicated Resident had an unplanned/unexpected weight loss related to poor food intake. A goal included she would consume 50% two of three meals/day and no significant weight loss would occur. Resident continued to lose a significant amount of weight after 2/2/23. Interventions included: give the resident supplements as ordered, monitor, and evaluate any weight loss. Determine the percentage lost and follow protocol for weight			

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	loss. Offer Resident substitute as requested as indicated. The resident prefers (blank). Weigh Resident at the same time of the day and record: (frequency). Resident is weight at (time) using (specific scale). During an interview with Licensed Practical Nurse (LPN) 13 and Qualified Medication Aide (QMA) 16 on 6/9/23 at 10:55 a.m., they indicated they felt that Resident 47's lost weight due to her having diarrhea. They indicated she had Imodium to help with the diarrhea and she still got diarrhea off and on. They indicated Resident was very independent with eating and would feed herself. During an interview on 6/12/23 at 1:36 p.m., the DON (Director of Nursing) indicated there was no follow up for the recommendation for an appetite stimulant. During an interview with Resident's family member, he indicated he discussed Resident's weight loss with the facility. He indicated she must go to the dining room for lunch and dinner daily. He indicated around Thanksgiving Resident acquired a UTI (Urinary Tract Infection) when she was living in AL (Assisted Living). She was sent to the hospital and stayed for 10 days. She returned to Robin Run's Healthcare Center. He indicated she had diarrhea at times. She had an as needed order for Imodium. He indicated she has cognitive loss and did not know to ask for the medication. She depended on staff to observe for diarrhea and administer the Imodium. A policy titled, "Weight Assessment and Intervention" dated March 2022 provided by the VPCO (Vice President of Clinical Operations) on 6/7/23 at 11:25 a.m., indicated " ...Resident weights are monitored for undesirable or unintended			

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	weight loss or gain. The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss. For example, cognitive or functional decline, chewing or swallowing abnormalities, pain, medication-related adverse consequences, environmental factors, increased need for calories and/ or protein, poor digestion or absorption, fluid and nutrient loss, and inadequate availability of food or fluids. Care planning for weight loss or impaired nutrition is a multidisciplinary effort and include the physician, nursing staff, the dietician, the consultant pharmacist, and the resident or resident's legal surrogate. Individualized care plans shall address to the extent possible: the identified cause of weight loss, goals and benchmarks for improvement and time frames and parameters for monitoring and reassessment. 3.1-46(a)(1) 3.1-46(a)(2)			
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on observation, interview and record review, the facility failed to ensure a resident received person-centered trauma informed care after she sustained severe burns to her extremities from an apartment fire. This deficient practice had the potential to effect 1 of 2 residents reviewed for	F 0699	F699 Trauma Informed Care 1. Res #173 will have Trauma Informed Care assessment completed by the DON/designee to address the needs related to recent trauma of being in a home	07/26/2023

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	Trauma informed care. accurate baseline care plan was put in place for a resident (Resident 173) to address immediate care concerns related to her skin integrity and medications. This deficient practice had the potential to affect 1 of 2 residents reviewed for new admission baseline care plans. Findings include: On 6/6/23 at 9:46 a.m., Resident 173 was initially observed. She was seated in a regular wheelchair in her room. She wore an oversize dress gown so that her bare legs and thighs were observed. She had intact, neat, clean odor free bandages to her bilateral thighs. Large portions of her bilateral shines were observed to be covered with scar tissue or scarred skin. During an interview on 6/7/23 at 8:41 a.m., Resident 173 indicated, she was doing ok, but she just wanted to go home. Her legs were observed a second time as described above. When asked about the condition of her legs, Resident 173 indicated she had been, "burnt up" in an apartment fire. She indicated, someone who lived next door to her had been smoking with oxygen around and it caused an explosion and subsequent fire. Resident 173 indicated she remembered sitting in her wheelchair in her apartment, watching T.V. when there was a loud bang. Next thing she knew, she was laying flat on her back with her head under a table, unable to move. She realized her legs were on fire, and the flames began to move up her body. Then a fireman came in and was able to get her out and saved her life. On 6/6/23 at 2:34 p.m., Resident 173's medical		fire where he/she sustained serious burns. Res #173 will have plan of care established, in collaboration with Res #173, to develop an individualized care plan that addresses past fire trauma and how to minimize re-traumatization during fire drills. 2. In house residents, who have experienced trauma recently or in the past are at risk: a. The Social Services Director (SSD) will review current inhouse residents, in collaboration with the resident and or their responsible party and complete a trauma informed care assessment to address if there are traumatic events from the present/past, evaluate presence of any symptoms, their relationship to the trauma, identification of triggers and develop a resident-centered plan of care to decrease exposure and re-traumatization. b. Residents identified will have plan of care updated to address needs/services as indicated by the SSD, DON/designee. 3. Systems or changes to ensure does not recur: a. The SSD, in collaboration with the resident, IDT and responsible party (if indicated) will complete the Trauma Informed Care Assessment per the regulatory requirements and policy and establish a plan of care to	

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	record was reviewed. She was a new admission resident with active diagnoses which included, but were not limited to, acute cystitis, (inflammation/infection of the bladder), hypertension (high blood pressure) and insomnia, (a sleep disorder). A Hospital Summary Report, dated, 4/16/23 indicated, Resident 173 had been admitted to the Burn Intensive Care Unit (ICU) for smoke inhalation with loss of consciousness and burns of her lower extremities as well as multiple sites on her upper extremities. A second Hospital Summary Report, dated, 5/24/23 indicated, Resident 173 had second-degree burns to her bilateral upper and lower extremities from an apartment fire. Upon her admission to Robin Run, a Trauma Informed Care Evaluation was completed on 5/30/23. Question 3 of the evaluation asked: "Have you ever been in a major natural or technological disaster, such as a fire ...? The question was answered, "no." The record lacked documentation of additional support services, plans of care, and/or interventions in place to provide person-centered care. On 6/7/23 at 12:01 p.m., a facility wide fire alarm sounded, and fire lights flashed. Upon observation, staff responded by closing resident doors as part of a head count, the ADON was observed to grab a fire extinguisher. Resident 173's door had already been closed, upon entrance to her room, she was observed		provide treatment and services if indicated and or interventions to minimize symptoms of trauma and decrease exposure to triggers that may re-traumatize the resident. b. Staff will receive education by the DON/designee regarding Trauma informed and Culturally competent care policy and communication and care of those residents that may be affected and their triggers and resident-centered approaches to decrease triggers. 4. Monitoring to ensure does not recur: a. DON/ designee will audit trauma informed care assessments and care plans of those residents that may be affected and their triggers and resident-centered approaches to decrease triggers are in place 3x weekly x4 weeks, then weekly x4 weeks then monthly x1. b. Re-education regarding the above, will be conducted as indicated, ongoing by DON/designee. c. Audits will be reviewed during quality assurance meetings, at least monthly by the QA committee x2 months. The QA committee will determine if audits need to continue or plan to be updated as indicated.	

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	seated in her wheelchair but appeared anxious as her eyes were wide, she pushed herself back and forth in the wheelchair and asked repeatedly, "do we need to leave, should we get out of here?" When the alarm stopped several moments later, Resident 173 appeared to relax, she stopped fidgeting in her wheelchair and indicated, "whew! That scared me, I'm glad that's over!" She indicated, the sound of the fire alarm and seeing everyone run around before they closed her door reminded her of the explosion and fire at her previous apartment. She indicated she had a flash back to laying under the table not being able to move, and with her door closed, she thought she might not get out. Resident 173 wanted to know if it was a scheduled fire alarm drill or if there was really a fire. Several firefighters were observed throughout the building as they responded to the fire alarm. During an interview on 6/7/23 at 12:17 p.m., the Assistant Director of Nursing (ADON) indicated, the alarm had not been a drill. Apparently, some of the work which was being done in the new Memory Care Unit had sent some dust or debris into the system which set off the alarm, but there had not been a fire. During a follow up interview on 6/7/23 at 12:23 p.m., Resident 173 was relieved to know there had not been an actual fire. A State Reportable Incident #120, dated 6/8/23, indicated, the facility had intermittent issues with fire systems specifically the enunciator panel. As a precaution a fire watch was started and the local fire department was notified. During an interview on 6/8/23 at 2:31 p.m., the			

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	Director of Nursing (DON) and ADON indicated they were aware Resident 173 had been in an apartment fire but did not realize the Trauma Informed Care assessment was incorrect. A house fire should be considered a traumatic event and person-centered interventions should be placed for Resident 173 or any resident who may have experienced trauma as the sound of the fire alarm may be a trigger to her experience. On 6/8/23 at 2:23 p.m., the ADON provided a copy of current facility policy title, "Trauma-Informed and Culturally Competent Care," revised 8/2022. The policy indicated, "Purpose: to address the needs of trauma survivors by minimizing triggers and/or re-traumatization ... traumatic events which may affect residents during their lifetime include: ...d. serious injury or illness ... f. forced displacement ... Triggers are highly individualized. Some common triggers may include: ... b. exposure to loud noises, or bright flashing lights ... Resident Assessment: 1. Assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers ... Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate ... Identify and decrease exposure to triggers that may re-traumatize the resident ...."			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the			

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	general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on observation and interview, the facility failed to properly store medications that were over the counter medications brought in by family members for 2 of 13 residents reviewed for medication storage (Residents 21 and 51). Finding include: 1. During a review of medication storage with RN 8 on 6/5/23 at 10:45 a.m., the 20-hall cart contained medications belonging to Resident 21. The medication bottles had her last name on them only. There were no pharmacy labels with directions on how to administer the medications.	F 0755	F755 Pharmacy Services/Procedures/Pharmacist/ Records 1. Res #21 will have over the counter (OTC) medications labeled by the pharmacy with directions on how to administer; aspirin, folic acid, vitamin D3 and calcium by the pharmacy. Res #51 will have multivitamin (OTC) labeled by the pharmacy with directions on how to administer by the pharmacy. 2. Inhouse residents receiving ordered OTC medications are at	07/26/2023

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	The medications included aspirin, folic acid, vitamin d3, and calcium. 2. Resident 51 had a bottle of multivitamin on the 20-hall cart with only his name on the bottle. There was no pharmacy label to indicate the directions for use. RN 8 indicated she thought the bottles only required the resident's name. During a medication pass on 6/8/23 at 12:13 p.m., Resident 20 and 51's medication bottles contained a piece of tape with the resident's name, dose and directions on each bottle. A policy titled, "Storage of Medication," was provided by the VPCO (Vice President of Clinical Operations) on 6/8/23 at 10:23 a.m. It indicated, " ...Medications are stored safely and properly following manufacturers and supplier's recommendations. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, staff members lawfully authorized to administer medications or resident's who are alert and responsible in self-administration ....". 3.1-25(a) 3.1-25(b)(1) 3.1-25(c)		risk: a. OTC medications will be reviewed by the DON/designee to ensure they have been labeled by the pharmacy with directions for use. OTC medications identified without directions for use will be ordered from the pharmacy with appropriate labeling for dispensing as required by the DON/designee. 3. Systems and or changes to ensure does not recur: a. Licensed nurses and medication aides will be educated for compliance, orientation and as indicated that OTC medications must be labeled with resident names and directions for use. b. Facility policy for OTC medication will be updated to include appropriate pharmacy labeling to include directions according to physician's orders and facility approved packaging system 4. Monitoring to ensure does not recur: a. DON/designee will audit OTC medications to ensure they have been labeled by the pharmacy with directions for use and according to facility policy 2x weekly x4 weeks, then weekly x8. b. Re-education of licensed nurses and medication aides regarding the above, will be conducted as indicated, ongoing by the DON/designee. c. Audits will be reviewed	

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			during quality assurance meetings, at least monthly by the QA committee x3 months. The QA committee will determine if audits need to continue or plan to be updated as indicated.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on observations, interviews and record review, the facility failed to ensure a gradual dose reduction (GDR) was attempted and/or a clinically contraindication was documented for a resident, (Resident 3) for 1 of 5 residents reviewed for unnecessary medications.	F 0757	F757 Unnecessary Drugs 1. Res #3, with a cognitive BIMs of 15, responsible for self with dx of schizoaffective disorder, major depression and anxiety will be evaluated for a gradual dose reduction (GDR) for psychotropic	07/26/2023

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	Findings include: On 6/5/23 at 2:37 p.m., Resident 3 was observed in the main dining room during program planning activity. Here eyes were closed, and her head was bowed. She did not engage in the activity. On 6/6/23 at 8:57 a.m., was observed in her room. She was laying on her bed, diagonally rather than horizontally. On 6/7/23 at 10:08 a.m., Resident 3 was observed. She appeared to be asleep in her bed. On 6/7/23 at 10:37 a.m., Resident 3 was observed. During a conversation, her voice was flat, and her face was expressionless. On 6/8/23 at 11:57 a.m., Resident 3 was observed up in the main dining room for a book reading activity. Her eyes were closed and her head nodded off, she did not participate. On 6/7/23 at 10:13 a.m., Resident 3's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, schizoaffective disorder, vascular dementia, major depressive disorder and generalized anxiety. She had physician's orders which included, but were not limited to; a. prazosin, 1 mg (milligrams) at bedtime for her schizoaffective disorder. (Prazosin is a medication used to manage several conditions and can cause unusual tiredness or weakness). b. escitalopram, 5 mg, once time a day for her		medications by the prescribing physician to determine if a GDR would be indicated or contraindicated and reviewed with Res #3. 2. Inhouse residents receiving psychotropic medications are at risk: a. DON/designee will continue to review residents receiving psychotropic medications with pharmacy consultant and attending physician monthly and/or as indicated for GDR; b. Residents identified by the consultant pharmacist, DON, and/or physician will be referred for GDR, in consultation with the resident and or responsible party. 3. Systems or changes: a. The DON/designee, IDT, consulting pharmacist and physician will evaluate residents receiving psychotropic medications to ensure a GDR was attempted and/or a clinical contraindication is documented. 4. Monitoring: a. DON/designee will audit residents receiving psychotropic medications to ensure a GDR was attempted and/or a clinical contraindication is documented weekly x4, then monthly x2. Audits will be reviewed during quality assurance meetings, at least monthly by the QA committee x3 months. The QA committee will determine if audits need to continue or plan to be	

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	major depressive disorder. (Escitalopram is an antidepressant medication that can also cause tiredness and weakness). c. haloperidol, 10 mg twice a day for her schizoaffective disorder. (Also known as Haldol, an antipsychotic medication that can cause dry mouth or increase salivation). d. buspirone, 7.5 mg twice a day for her anxiety. (Also known as Buspar, an antianxiety medication that can cause dizziness and drowsiness). e. trazadone, 50 mg at bedtime for her major depressive disorder. (Trazadone, is an antidepressant medication that can cause drowsiness and dry mouth). Resident 3's pharmacy recommendations were reviewed. A recommendation, dated, April 2023, indicated Resident 3 had a recent fall with fracture, so a recommendation was made to review her high risk meds which included but were to Haldol. The recommendation was reviewed by the Medical Director (MD), however no changes or documented contraindications were documented for the Haldol. During an interview on 6/8/23 at 10:30 a.m., the Director of Nursing (DON) indicated a GDR had not been attempted since Resident 3 was first started on Halol in 2021. During an interview on 6/8/23 at 11:01 a.m. the MD indicated he had not attempted a GDR for Resident 3's Haldol as he felt that she would still have severe side effects. He indicated there were three exclusionary diagnoses that did not require GDRs those categories were: Schizophrenia,		updated as indicated.	

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	Tourette's Syndrome and Huntington's disease. During an interview on 6/8/23 at 1:02 p.m., the Consulting Pharmacist (CP) indicated, a GDR for a resident's antipsychotic medication may not be recommended for a resident with documented ongoing signs or symptoms. Typically, a GDR should be attempted twice in the first year after a new antipsychotic was started, then once annually thereafter. In Resident 3's case, he would expect there to be documented reasons why a GDR should not be conducted. Resident 3's record lacked documentation of recent signs, symptoms, or behaviors exhibited by the resident. Her quarterly medication and behavior reviews also lacked documentation of reasons to continue her high-risk medications at the same dosages. Resident 3's Psychotherapy Progress notes were reviewed from 9/1/22-current. All of the treatment notes indicated the following: "Treatment Objectives: Per the current treatment plan, services are generally focused on addressing the problems of depression ... the chief aim of psychotherapy was the pursuit of goals pertaining to depression ...." All of these psychotherapy notes also indicated Resident 3 exhibited signs/symptoms for suicide/homicide. The record lacked documentation of comprehensive services/support/monitoring of her Schizoaffective disorder. During a follow up interview on 6/8/23 at 1:35 p.m., the MD indicated, in preparation for the follow up interview, he found that there did need to be a documented reason for the contraindication of			

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	reducing Resident 3's Haldol. At that time, he wrote an order to remove Resident 3's diagnoses of vascular dementia, reclassified her diagnosis of schizoaffective disorder to Schizophrenia and provided a copy of current facility policy. The policy was titled, "Gradual Dose Reduction (GDR) in Skilled Nursing Facilities Quick Reference Guide," effective 10/24/22. The policy indicated, "GDR requirements are changing ... a GDR may be considered clinically contraindicated, if the: "continued use is in accordance with relevant current standards of practice AND the prescriber has documented the clinical rationale explaining why any attempted dose reduction would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder ...." 3.1-48(a)(5)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents			

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	from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure staff used appropriate hand hygiene while assisting residents with eating for 3 of 3 residents observed being assisted with dining (Resident 9, 21, and 24). Findings include: On 6/5/23 at 12:21 p.m., Certified Nursing Aide (CNA) 12 was assisting Resident 24 with eating. She provided her a bite of pasta. At 12:24 p.m., without washing her hands or hand gelling, she used Resident 21's utensils with her bare hands and cut up more of her food. She went back to assisting Resident 24 with eating. On 6/5/23 at 12:23 p.m., CNA 9 moved a chair with her bare hands near Resident 24, she did not hand wash or sanitize before assisting her with eating. On 6/5/23 at 12:26 p.m., CNA 9 stopped assisting Res 24, she did not hand washing or sanitize and assisted Resident 21 with spearing her food using her fork with her bare hands and helping it into Resident 21's hand. CNA 9 indicated Resident 21 did not want help, but she needed it. Then, with hand washing or gelling, she went back to assisting Resident 24 with eating. On 6/5/23 at 12:31 p.m., CNA 9 stopped assisting Resident 24, she did not hand washing or sanitize and assisted Resident 21 with spearing her food using her fork with her bare hands and helping it	F 0812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 1. Res #9, 21 and 24 did not have any adverse effects from the inappropriate hand hygiene during meal. 2. Inhouse residents are at risk for inappropriate hand hygiene during meals. 3. System or changes to ensure appropriate practice; a. Nursing staff will receive education by DON/ADON IP/designee regarding hand hygiene between residents requiring assistance in the dining room and after touching surfaces during meal service for compliance, orientation and as indicated. 4. Monitoring to ensure appropriate practice: a. DON/ADON IP/designee will audit nursing staff hand hygiene practices during meal service 3x/wk x4 weeks, weekly x4 weeks to ensure appropriate hand hygiene practices are being followed. b. Re-education regarding appropriate hand hygiene during meal service will be conducted as indicated, ongoing by the DON/designee.	07/26/2023

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	into Resident 21's hands again. Then, without hand washing or gelling. Then, went back to assisting Resident 24 with eating. On 6/5/23 at 12:33 p.m., CNA 9 stopped assisting Resident 24, she did not hand wash or sanitize and assisted Resident 21 with spearing her food using her fork with her bare hands and helping it into Resident 21's hands again. Then, she went back to assisting Resident 24 with eating. On 6/5/23 at 12:39 p.m., CNA 12 was observed getting a drink for Resident 9, she returned to the table. She touched the arms of the chair with her bare hands and went back to assisting Resident 9 with eating. On 6/8/23 at 3:57 p.m., the Director of Nursing (DON) indicated the staff should hand wash before assisting resident with eating, wash hands between residents, and if they touched anything between feeding residents, they should hand wash again. A current policy, titled, "Handwashing/Hand Hygiene," was provided by the Vice President of Clinical and Regulatory Compliance (VPCRC), on 6/8/23 at 10:00 a.m. A review of the policy indicated, " ...This facility considers hand hygiene the primary means to prevent to spread of infections ...All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors ...." 3.1-21(i)(3)		c. Audits will be reviewed during quality assurance meetings, at least monthly by the QA committee x2 months. The QA committee will determine if audits need to continue or plan to be updated as indicated.	
R 0000 Bldg. 00				

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	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00408400. This visit included a Recertification and State Licensure Survey. Complaint IN00408400 - State Residential deficiencies related to the allegations are cited at R0239.. Survey dates: June 5, 6, 7, 8, 9 and 12, 2023. Facility number: 001156 Residential Census: 53 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 22, 2023.	R 0000	Please accept the following plan of correction as credible evidence of compliance to the deficiencies cited during our recent Annual Survey at Robin Run Village. Hopefully, you will find our remedies to be both sufficient and thoroughly explained. The Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. We are requesting Paper Compliance Review with the submission of these remedies. If after reviewing the plan of correction you have any questions, please do not hesitate to contact us.	
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) 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			

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	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 care for residents with dementia. Based on interview and record review, the facility failed to ensure a qualified Dementia Care Director was appointed for the secured memory care unit. This deficient practice had the potential to effect 22 of 22 residents who resided on the secured memory care unit. Findings include: Upon the survey entrance on 6/8/23 at 3:10 p.m., the Assistant Director of Nursing (ADON) and the Assisted Living Manager (ALM) were present. When asked who the Dementia Care Director (MCD) was, there was no definitive answer, and the ADON would look into it. On 6/8/23 at 3:15 p.m., the Assisted Living (AL) employee records list was provided. The MCD position was left blank. During an interview on 6/12/23 at 11:20 a.m., the ADON indicated, there had been a MCD, but that person had walked out without notice, months ago, but eh ADON could not remember the date. Since then the facility had an interim administrator	R 0095	R095 Administration and Management: 1. No residents on the Memory Care Unit (MCU) were adversely affected by the not having a Memory Care Director (MCD). 2. Inhouse MCU residents are at risk of being affected by not having a MCD. 3. Systems or changes to ensure does not recur: a. The licensed administrator, Executive Director, is the designated director for the Alzheimer’s and dementia care unit and has received the minimum required dementia-specific 12-hour training and meets all requirements. b. The facility will continue to follow the requirements for designating a MCD. 4. Monitoring: a. Certificate of course	07/26/2023

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	and an AL Manager. The position was open and posted for hire, but currently there was not a qualified MCD. During an interview on 6/12/23 at 12:20 p.m., the AL Manager indicated she was newly hired and had only been in the position for about a month. Her responsibilities were mainly to act as the AL Manager and provide clinical oversight for AL staff. She indicated she was not the MCD. During an interview on 6/12/23 at 3:20 p.m., the DON indicated there was no MCD. On 6/9/23 at 11:24 a.m., the Vice President of Regulatory Compliance provided a copy of current, but undated facility policy titled, "Memory Care Mission and Philosophy." The policy indicated, " ...A program Director with an educational background of Alzheimer's/Dementia care to oversee and carry out the mission and philosophy of the memory care community ...."		completion and requirements will be on file with administration. 5.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on			

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	site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure that at least one awake staff member, was first aid certified for 21 of 21 observations of the actual worked weekly nursing schedule. This deficient practice had the potential to effect 53 of 53 residents who resided in the facility. Findings include: On 6/12/23 at 12:00 p.m., first aid qualified staff were compared to the nursing schedule for the week of 6/3/23 through 6/9/23. Review of the schedule revealed, the facility had not ensured, any first aid certified staff were on duty for the day, evening and night shift of the forementioned schedule. During an interview with the ADON (Assistant Director of Nursing) on 6/12/23 at 12:20 p.m., she indicated the staff were CPR (Cardio-Pulmonary Resuscitation) certified but not first aid certified. She indicated there was no policy regarding requiring first aid certified staff on each shift but the facility followed state rules which required first aid coverage.	R 0117	R117 Personnel 1. No residents were adversely affected, 2. Inhouse residents were at risk for if a first aid certified staff member was not on duty, 3. Systems or changes to ensure does not recur, a. Assisted living scheduler will ensure prior to the shift that a first aid certified staff member is on duty during the shift, b. First aid certification course was conducted on site 6.29.23 and 7.7.23 for assisted living staff. c. First aid certification classes will be offered and provided on or off site to ensure staff have first aid certification, d. Assisted living director/designee will be responsible for tracking certifications and expirations for personnel first aid training and ensuring at least (1) certified first aid staff on each shift 4. Monitoring to ensure does not recur: a. Assisted living director/designee will be	07/26/2023

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			responsible for tracking certifications and expirations for personnel first aid training and ensuring at least (1) certified first aid staff on each shift b. The above will be discussed during the Quality Assurance meeting at least monthly x3 by the AL Director. The QA Committee will determine if auditing needs to continue and frequency; plan to be updated as indicated.	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observations, interviews and record reviews, the facility failed to ensure resident's environments remained free from the potential for accidents when bedrails were applied without evaluation or assessment and therefore were not monitored or maintained in a safe operating	R 0148	R148 Sanitation and Safety 1. Res 7, 11 and 31 had bed rails removed due to safety risks with approval received from. resident and or responsible party by the DON/designee.	07/26/2023

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	condition for 3 of 3 residents reviewed for assistive devices, (Residents 7, 11 and 31). Findings include: On 6/12/23 at 9:40 a.m., Resident 7 was observed. At that time, she was seated in her wheelchair in her room next to her bed. Her bed was observed to have an assistive device installed at the head of the bed (HOB). It was a large, white, metal-bar framed railing system, with four leg posts, and rails that stuck out beside the mattress. The two top post-legs of the frame were completely unsecured and wobbled back and forth and off the ground. There was a considerably large gap between the mattress and the rail. On 6/12/23 at 9:42 a.m., Resident 7's bed device was observed with Qualified Medication Aide (QMA) 10. She indicated she did not know if there were any rules about whether residents could have devices such as that, but she indicated this device looked very unsafe as it was not tightly secured, and the large gap between the rail and mattress could get the resident stuck or trapped of she rolled over too far. During an interview on 6/12/23 at 9:45 a.m., QMA 10 indicated there was only one other resident to her knowledge that used a bed rail and she walked to Resident 11's room. Upon entrance, the resident was not in her room, but her bed was observed to have a metal rail device installed to the left side of the bed. There was a large gap between the mattress and the rail. QMA 10 indicated, Resident 11 was often found trying to get out of bed and slid down the side. She would be found almost on the floor and holding onto the rail with her shoulder between the mattress and rail. She was moved closer to the nurses' station for better		2. Residents using bed/safety rail devices will be assessed to ensure they can appropriately negotiate the rail for transfers and bed mobility and appliance does not have over 3 inches of space between mattress and device. Devices will be removed, after communication with resident and/or responsible party and a facility approved device will be placed by maintenance, DON, assisted living clinical manager/designee, 3. Systems/Changes to ensure does not recur: a. Bed safety rails will be applied by maintenance if assessed to be appropriate and approved by the facility administration. b. Residents bringing in bed safety rail appliances will have appliance reviewed by maintenance, DON, assisted living clinical manager/designee prior to application or facility approved device applied. Resident and or responsible party will be educated by nursing staff about this safety process if appliances are brought in. c. During each residents Service Plan reviews the DON, assisted living clinical manager/designee will review the resident's bed to ensure if a bed rail device is being used it will be re-evaluated during that time and as indicated.	

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	supervision, but that did not stop Resident 11 from attempting to self-transfer. QMA 10 indicated both of the rails appeared to be poorly installed, and she would let maintenance know to see if they could be tightened or removed. On 6/12/23 at 9:50 a.m., Resident 31's room was observed as she walked in. Her bed was against a wall, and there was a quarter metal railing device installed to the open side of the bed. There was a considerable gap between the mattress and rail. During an interview on 6/12/23 at 3:20 p.m., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) indicated, they were unaware of the bed mobility devises installed in Assisted Living (AL). They were interim administrators for AL until a full time Director/Administrator was hired. The DON indicated, assistive devices could be allowed but only after the proper evaluation of the resident and devise had been completed. Further ongoing monitoring of the devises would be required to ensure they were maintained in a safe and functional manner. On 6/12/23 at 12:20 p.m., Residents 7, 11, and 31's medical record were briefly reviewed related to assistive devises. Their records lacked documentation of an initial evaluation for the mobility device. Their records lacked documentation of a service plan with descriptive information related to bed mobility devises. Their physician's orders lacked documentation for the need/ability to use/have mobility devices. Their records lacked documentation of ongoing		d. Nursing staff will also receive education by the DON/designee regarding the above process as indicated. 4. Monitoring to ensure does not recur: a. The DON/designee will audit bed/safety rail devices monthly x3 to ensure bed safety appliance does not have over 3 inches of space between mattress and device. If identified maintenance/designee will be notified and appropriate device placed if indicated. b. QA Committee will review audits monthly during the QAPI meeting to determine if process being followed and if more frequent or continued monitoring needs to continue. Plan will be updated if indicated by the QA committee.	

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	maintenance and evaluation of the devices to ensure they were still appropriate for each resident. Their records lacked documentation of personal property inventory. On 6/12/23 at 11:25 a.m., the ADON provided a copy of current facility policy titled, "Assistive Devises and Equipment," revised 1/2020. The policy indicated, "Our facility maintains and supervises the use of assistive devises and equipment for residents. Certain devices and equipment that assist with resident mobility, safety and independence are provided for residents ... recommendation for the use of devices and equipment are based on the comprehensive assessment and documented in the resident care plan ...the following factors are addressed to the extent possible to decrease the risk of avoidable accidents associated with devices and equipment: a. appropriateness for the resident condition ... b. person fit ... c. device condition- devices and equipment are maintained on a schedule and according to manufactures instructions ... d. staff practices- staff are required to demonstrate competency on the use of devises and equipment and are available to assist and supervise residents as needed ... If residents provide their own assistive devices, these items are documented as personal property and made available for that resident's use only ...."			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more			

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	155505	A. BUILDING 00 B. WING	06/12/2023

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	often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on observation, interview and record review, the facility failed to ensure a resident, (Resident B) with a history of falls, received timely comprehensive assessments and service plans to prevent the potential for falls and failed to implement new interventions after she experienced a fall with fractures for 1 of 3 residents reviewed for falls. Findings include: On 6/12/23 at 8:30 a.m., Resident B was observed. She appeared to be asleep in her bed. She was covered with a blanket and her eyes were closed and the lights were off. She was positioned vertically across the bed and not horizontally, her legs hung off the edge of the bed, as if she had been sitting on the edge of the bed and laid/leaned over to the side for a nap. On 6/12/23 at 10:30 a.m., Qualified Medication Aide (QMA) 10 indicated Resident B was confused most of the time, she had some early signs of dementia, so she needed lots of reminders. On 6/12/23 at 11:15 a.m., Resident B's medical record was reviewed. She had diagnoses which included, but were not limited to, type II diabetes mellitus (a blood sugar disorder), hypertension (high blood pressure) and chronic kidney disease. Her record lacked a formal diagnosis of dementia, however, her most recent Physician's Progress note dated 6/1/23 indicated she had dementia, short term memory loss, and difficulty planning or organizing, personality changes, and compliance	R 0214	R214 Evaluation 1. Res B had a respiratory infection, self-limiting change in condition (short term) at the time of the fall 12.5.22. Frequent checks during acute illness by nursing and re-education on how to use the pendant to call for assistance was implemented by the nurse at that time but was not documented. Review of Res B service plan will be completed by the DON/designee to ensure interventions are in place for risk of falls and preventative measures to reduce further falls and that service plan has been updated for semiannual or known substantial change, including but not limited to, dx of dementia, short term memory loss, difficulty planning or organizing, personality changes and compliance with medication. 2. Inhouse assisted living residents are at risk to ensure service plans to evaluate individual needs are updated at least semiannually and upon a known substantial change, and as indicated. An audit of inhouse residents will be completed by the DON/designee to ensure service plans have been updated for completion and identify fall risks and interventions to reduce falls as well as other substantial areas of change if indicated.	07/26/2023

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	with medication. A service plan, dated 5/6/21, indicated Resident B required assistance and prompts for escorts and mobility as she was a high risk for falls and had experiences a fall in the last twelve months. The record lacked documentation of the completion of a bi-annual resident evaluation and service plan for November 2021, May 2022 and November 2022. Resident B experienced a fall which resulted in multiple left side rib fractures, as evident below: (the fall occurred a month after her service plan would have been due in November of 2022). A nursing progress note, dated 12/5/22 at 1:55 p.m., indicated, Resident B was found lying on her back in her room with her walker flipped over beside her. She was assessed and no injuries were noted at that time. Resident B stated, "that she was getting up out of the chair to get her walker, for some reason tilted around and fell." She denied any pain at that time. The record lacked documentation that any new intervention had been put in place after the fall. A nursing progress note, dated 12/5/22 at 10:03 p.m., indicated Resident B complained of left back and rib pain. Tylenol was given. A family member had come for a visit but declined sending Resident B to the hospital at that time. A nursing progress note dated 12/6/22 at 6:22 a.m., indicated Resident B continued to complain of left side pain. Her as needed Ibuprofen had already been administered earlier at 4:3 a.m., and decided to move to her recliner chair and watch		3. Systems or changes to ensure does not recur: a. Licensed nurses will receive education regarding evaluation of individual residents needs and shall be initiated prior to admission and updated semiannually, upon a known substantial change in the resident's condition, or more often at the resident's or facility's request by the DN/designee. b. Licensed nurses and the IDT will receive education regarding assessing and updating services plans if a resident has a fall to prevent the potential for further falls and implement new interventions, to the extent possible, after a resident has a fall by the DON/designee. 4. Monitoring to ensure does not recur: a. DON/designee will audit service plans for 4 residents monthly x3 months to ensure service plans are completed timely and include falls prevention with updated interventions if indicated, substantial changes in condition if indicated. b. The above audits will be reviewed monthly by the QA Committee to determine compliance with the above system and if further auditing needs to be continued. Plan to be updated as indicated by QAPI. 5.	

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	T.V. A nursing progress note dated 12/6/22 at 9:11 p.m., indicated, Resident B continued to complaint of moderate amounts of left rib pain, and she was given more Tylenol. A nursing progress note dated 12/7/22 at 4:23 a.m., indicated Resident B complained of increase and sharp pain under her left breast and her as needed pain medication was no longer effective. The resident stated the pain was intolerable and requested to go to the hospital. 911 was called and she was transferred to the hospital. She returned from the hospital on 12/8/22 with a diagnoses of multiple left rib fractures. A follow up Physician's progress note, dated, 12/13/22 indicated, "patient had a fall on 12/5/22 but denied injury. Began complaining of back/rib pain the next day and was transferred to [ER] where she was found to have multiple left sided rib fractures. She was discharged back home on 12/8/22 with a lidocaine patch ... Patient does continue to complain of left sided rib pain, but nursing staff states she is up ambulating, eating well and seemingly, overall, at baseline ...." Her current service plan was reviewed. It was initiated on 2/10/23 but was incomplete. A section for "cognition" lacked documentation of her current level of cognition, goals, and/or interventions. And a section titled, "falls" indicated Resident B required reminders, but did not specify what reminder, frequency of reminders or other additional interventions. During an interview on 6/12/23 at 3:20 p.m., the Director of Nursing (DON) and Assistant Director			

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	of Nursing (ADON) indicated, they were aware there were several service plan issues since they had taken over interim administration of the Assisted Living facility. The DON indicated, it was her expectation that service plans and resident evaluations should be completed a minimum of state requirements bi-annually, but more often as the resident needed. After a resident experienced a fall, immediate interventions should have been put into place until the Interdisciplinary Team (IDT) would review the fall and determine if the intervention was appropriate or if another interventions needed to be put in place. Service plan should be updated to reflect the IDT decision and outcome. On 6/12/23 at 1:30 p.m., the DON provided a copy of current facility policy titled, "Fall and Fall Risk, Managing," revised 3/2018. The policy indicated, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the residents from falling and to try to minimize complications from falling ... Resident-Centered Approached to Managing Fall and Fall Risk: 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls ...."			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the:			

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	(A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record reviews and interviews, the facility failed to have service plans signed by the resident or representative and/or failed to complete a service plan timely for 8 of 8 residents reviewed (Resident 1, 5, 19, 36, 43, 54, 55, and C). Findings include: 1. A comprehensive record review was completed on 6/9/22 at 2:00 p.m. Resident 1 had the following diagnoses, but not limited to COPD (Chronic Obstructive Pulmonary Disease), hypertension, hyperlipidemia, and weakness. Resident 1 had a service plan dated 3/3/23. It was not signed by the resident or representative. 2. A comprehensive record review was completed	R 0217	R217 Evaluation 1. Res #54 no longer resides at facility 4.1.23., Res #55 no longer resides at facility 5.15.23, Res #C no longer resides at facility 6.23.23. Res #1, 5, 19, 36 and 43 will have services plans completed/updated and reviewed with resident and or responsible party in person or over the phone conferences by the DON/designee. The service plan will be signed by the responsible party or noted verbal review and name if verbal review over phone. Attempts with email verification of discussion with responsible party	07/26/2023

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	on 6/9/22 at 1:50 p.m. Resident 5 had the following diagnoses, but not limited to unspecified dementia, mood disturbances, anxiety, chronic embolism, and thrombosis of unspecified deep veins of right lower extremity, essential hypertension, urinary incontinence, and major depressive disorder. Resident 5 had a service plan dated 3/20/23. The service plan was not signed by the resident or representative. 3. A comprehensive record review was completed on 6/9/23 at 1:20 p.m. Resident 19 had the following diagnoses but not limited to essential hypertension, atherosclerotic heart disease, hyperlipidemia, benign prostatic hyperplasia, spinal stenosis, mitral valve prolapses, and major depressive disorder. Resident 19 had a service plan dated 2/10/23. Resident 19 or a family representative did not sign the service plan agreement. 4. A comprehensive record review was completed on 6/9/23 at 11:15 a.m. Resident 36 had the following diagnoses, but not limited to dementia, hyperlipidemia, and non-Hodgkin lymphoma. Resident 36 did not have a service plan on her record. 5. A comprehensive record review was completed on 6/9/23 at 12:20 p.m. Resident 43 had the following diagnoses, but not limited to edema, cellulitis left lower extremity and hypertension. Resident 43 had a service plan dated 2/9/23. The service plan agreement was not signed by the resident or representative. 6. A comprehensive record review was completed on 6/9/23 at 1:30 p.m. Resident 54 had the following diagnoses, but not limited to unspecified dementia, difficulty in walking,		will be attempted by the DON/designee. 2. Inhouse residents are at risk: a. In house residents will be audited to ensure service plans up to date and or initiated and reviewed verbally in person with resident and or responsible party and signed. For responsible parties out of town, attempts to receive and email verification of review will be completed by the DON/designee. 3. Systems or changes to ensure does not recur: a. DON/designee will receive education from the Quality Assurance RN/designee regarding completion of a resident evaluation, identifying and documenting the services to be provided by the facility according to the regulatory requirements including timely and reviewed and signed by the resident and or responsible party by a licensed nurse, b. A schedule of service plans will be created upon admission and updated if substantial changes and kept by the AL Nursing Manager and DON/designee. c. Service plans will be reviewed with resident and or responsible party by the DON/designee and signed within 30 days of the completion date of the service plan.	

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	hyperlipidemia, essential hypertension, major depressive disorder, type 2 diabetes, and anxiety disorder. Resident 54 had a service plan dated 2/9/23. The service plan agreement was not signed by the resident or representative. 7. A comprehensive record review was completed on 6/9/23 at 1:40 p.m. Resident 55 had the following diagnoses but not limited to anxiety, Alzheimer's dementia, and hypertension. Resident 55 had a service plan dated 2/24/23. The service plan agreement was not signed by the resident and/or representative. During an interview with the ADON (Assistant Director of Nursing) on 6/12/23 at 2:00 p.m., she indicated what she provided was what the resident had on file for the resident's service plans.8. A progress note, dated 3/21/23 at 8:14 a.m., indicated a Certified Nursing Aide (CNA) was assisting Resident C with transferring from his bed to his wheelchair with his walker present. He lost his balance and fell hitting the night stand with his left shoulder. He was observed laying on his left side. He denied hitting his head and had no change in his level of consciousness. Management and his Power of Attorney (POA) were called. It was a witnessed fall. The resident indicated he had intense back and bilateral (both) hip pain, 10/10 of the pain scale. He was sent out to a local hospital. On 6/12/23 at 10:43 a.m., Resident C's service plan was reviewed. The fall care plan was not updated after his 3/21/23 fall and trip to the ER. a. He did not have a wound or risk for a wound care plan. b. His Safety care plan did not have a goal or any interventions. c. His Communication care plan did not have any		4. Monitoring to ensure does not recur: a. AL Nursing Manager and DON/designee will review weekly service plans needing completed and when review with the resident and or responsible party has been scheduled. b. DON/designee will audit completion and review of service plans weekly x4 weeks then every 2 weeks x4 weeks then monthly x1 for compliance of above system. c. Audits will be reviewed in monthly QA Committee meeting to ensure compliance and if audits need to continue. Plan to be updated as indicated.	

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	interventions. d. His Personal Hygiene/Oral Care care plan did not have any goals. e. His Personal Shopping care plan did not have any goals. f. His Technology Use care plan did not have any goals, the interventions were not clear and specific. g. His Evacuation care plan did not have any goals. A weekly skin review, dated 6/7/23, indicated Resident C had an open area on his sacrum/coccyx 4 x 0.1 x 0.1 cm. It did not indicate an infected heel wound. His physician's orders, dated 6/10/23, indicated to clean wound to left heel with wound cleanser or soap and water, pat dry, apply triple antibiotic ointment and gauze, three times a day and give doxycycline (antibiotic) 100 mg, twice a day, for left heel wound for 7 days. A current policy, titled, "Service Plans," was provided by the DON, on 6/12/23 at 1:30 p.m. A review of the policy indicated, " ..." ...A resident-centered service plan is created and maintained for every resident. The purpose of the service plan is to provide a centralized coordination of the services that will be provided to each resident , based on his or her individual needs, abilities, and preferences ...The service plan should address, but is not limited to ...fall history and/or risk ...." A current policy, titled, "Falls and Fall Risk, Managing," was provided by the DON, on 6/12/23 at 1:30 p.m. A review of the policy indicated, " ...The staff, with the input of the attending physician, will implement a resident-centered fall			

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	prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls ...."			
R 0239 Bldg. 00	410 IAC 16.2-5-4(c) Health Services - Nonconformance (c) Each facility shall choose whether or not it administers medication or provides residential nursing care, or both. These policies shall be delineated in the facility policy manual and clearly stated in the admission agreement. Based on observations, interviews and record review, the facility failed to prevent the potential for accidents and/or medication errors when medications were left in a resident's (Resident B) room for 1 of 3 residents reviewed for self-administration of medications. Findings include: A confidential complaint indicated, Resident B had no memory, and some of the staff leave medication with the resident and do not stay to be sure she takes it. Medication has been found in cups in her room and on her floor. On 6/12/23 at 8:30 a.m., Resident B was observed. She appeared to be asleep in her bed. She was covered with a blanket and her eyes were closed and the lights were off. Next to her recliner chair, there was a tray table with a breakfast plate that had not been touched. It remained covered an no food had been consumed. Additionally, there was a medication cup with a single, large white tablet in it. On 6/12/23 at 10:30 a.m., Qualified Medication Aid (QMA) 10 indicated she had not been into Resident B's room for morning medication yet, as	R 0239	R239 Health Services 1. Res B requires assistance with administration of medications by a licensed nurse or Qualified Medication Aide (QMA) due to dementia. 2. In house residents unable to self-administer medications are at risk: a. A review of all inhouse residents will be completed by the DON/designee to ensure there are no medications at bedside, b. If medications observed at bedside are identified, the responsible party will be contacted to pick up the medications and policy reviewed with the resident and or responsible party pertaining to self-administration of medications. 3. Systems or changes to ensure does not recur: a. Nursing staff will receive education regarding facility policy for self-administration of medications and safety concerns with leaving medications at	07/26/2023

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	the resident preferred to sleep in. She was on her way to encourage Resident B to get up so that she could check her blood sugar and administer her morning medications. Upon entrance to her room at this time, QMA 10 observed the tablet beside her breakfast tray. She indicated it had to have been left over from the previous days medication pass since she had not pulled medications for the resident yet. QMA 10 indicated, Resident B was quite forgetful and was not able to self-administer her medications. Medications should never be left in the residents rooms, because then the nurse could not guarantee if the resident had taken them or not. She removed the pill cup and disposed of the medication. On 6/12/23 at 11:15 a.m., Resident B's medical record was reviewed. She had diagnoses which included, but were not limited to, type II diabetes mellitus (a blood sugar disorder), hypertension (high blood pressure) and chronic kidney disease. Her record lacked a formal diagnosis of dementia, however, her most recent Physician's Progress note dated 6/1/23 indicated she had dementia, short term memory loss, and difficulty planning or organizing, personality changes, and compliance with medication. A service plan initiated 2/10/23 indicated Resident B required medication management, but lacked documentation or specification of her level of assistance. Upon the survey entrance on 6/8/23 at 3:10 p.m., the Assistant Director of Nursing (ADON) and the Assisted Living Manager (ALM) were present. A list of residents who administered their own medication was requested but the ADON and		bedside for compliance, during orientation and as indicated by the DON/designee, b. Residents choosing to self-administer medications will have a Self-Administration assessment completed by a licensed nurse and physician or nurse practitioner review and order for self-administration and service plan updated as indicated. Self-administration assessments will be completed with semiannual service plan, substantial change in condition or more frequently if indicated by the facility. c. Nursing staff identifying medications left at bedside for residents without self-administration orders will immediately notify their supervisor and be investigated. 4. Monitoring to ensure does not recur: a. DON/designee will audit med passes to identify if medications are being left with a resident that does not have self-administration orders weekly x4, then monthly x2. b. Audits will be reviewed by the QA Committee to determine if auditing needs to continue. Plans to be updated as indicated by the QA Committee.	

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	ALM indicated, no one self-administered their medications, the facility provided all medication management for all residents. During an interview on 6/12/23 at 11:00 a.m., the ALM indicated, medications should not be left in resident's rooms. On 6/12/23 at 2:25 p.m., the ADON provided a copy of current facility policy titled, "Self-Administration of Medications," revised 2/2021. The policy indicated, " ...if it is determined that a resident cannot safely self-administer medications, the nursing staff administer[s] the resident's medication ... any medication found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party ...." This Residential Tag related to Complaint IN00408400.			