STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155290	A. BUILDING 00 B. WING	01/12/2023

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ST ELIZABETH HEALTHCARE CENTER	701 ARMORY RD DELPHI, IN 46923

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00381691, IN00381685, IN00381305, IN00390095 and IN00388615. This visit also included a State Residential Licensure Survey. Complaint IN00381691 - Substantiated. Federal/State deficiencies related to the allegations are cited at F565, F677, F690 and F725. Complaint IN00381305 - Substantiated. Federal/State deficiencies related to the allegations are cited at F565, F725 and F842. Complaint IN00390095 - Substantiated. Federal/State deficiencies related to the allegations are cited at F565, F725 and F812. Complaint IN00381685 - Substantiated. Federal/State deficiencies related to the allegations are cited at F565, F677, F690 and F725. Complaint IN00388615 - Substantiated. Federal/State deficiencies related to the allegations are cited at F921. Survey dates: January 4, 5, 6, 9, 10, 11 and 12, 2023 Facility number: 000187 Provider number: 155290 AIM number: 100267300 Census Bed Type: SNF/NF: 44 SNF: 12 Residential: 25	F 0000	The submission of this plan of correction does not indicate an admission by St. Elizabeth Healthcare Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the resident of St. Elizabeth Healthcare Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility herby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. The facility respectfully requests from the department a desk review for substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Lewis	RN Clinical Support	02/20/2023

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

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	Total: 81 Census Payor Type: Medicare: 17 Medicaid: 30 Other: 9 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on January 23, 2023.			
F 0565 SS=D Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate			

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	their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on interview and record review, the facility failed to resolve resident council concerns and grievances for 3 of 3 residents reviewed for resident council concerns. (Resident R, Q and S) Findings include: During the resident council interview, on 1/6/23 at 2:48 p.m., the residents indicated it took a long time to get call lights answered and the facility would indicate they were short CNAs, but the residents would find them sitting at the nurse's station. Sometimes it took 45 minutes to an hour for help and some residents have waited 2 hours. They were not receiving showers timely and sometimes they had to find the staff member to get a shower. Resident R indicated she had to complain at least three times to get her showers. Residents Q and S indicated they did not always get two showers a week. They are told by the CNAs they did not have enough staff to complete showers. The residents indicated they felt their concerns were not getting resolved. A resident concern form, dated 1/31/22, Resident	F 0565	All resident concerns voiced on 1/31/22, 2/14/22, and 5/9/22 were addressed with the appropriate department leader and followed up on as appropriate. All residents had the potential to be affected by this alleged practice. Department leaders will be re-inserviced on the policy titled "Resident Council" by Home Office Clinical Support or designee. The Executive Director or designee will audit resident council minutes monthly to ensure grievances are being addressed by the appropriate department leader. The ED or designee will report findings to QAPI for 6 months or until 100% compliance is maintained.	02/06/2023

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	R indicated it took a very long time to get her light answered. The response from the staff member (no signature was on the form) indicated a discussion with the resident and staff was completed. Staff was reminded about answering call lights quickly. It may not be immediate due to care, but they would get there as soon as possible. The facility would emphasize answering call lights during staff meetings. The staff member indicated he/she had personally answered the call light. The resident council meeting minutes, dated 2/14/22 at 10:30 a.m., Resident R indicated the call lights were still a problem. The response from the RN indicated emphasis was placed on caregivers and employees committed to answer the call lights as soon as possible as a priority. The Director of Health Services and Executive Director would round to ensure call lights were answered timely throughout the day. The resident council meeting minutes, dated 5/9/22 at 10:00 a.m., indicated the residents felt like things had not been resolved. A resident council response form, dated 5/9/22, indicated the residents had concerns about staff answering call lights and then not returning with help. The staff response to the concern indicated staff returned as soon as they could and when another caregiver was available. This could take longer than we wish it to, but staff will continue to try to improve in answering call lights and meeting needs faster. A resident concern form, dated 12/19/22, indicated a resident reported 2 days ago she was put on the toilet and left for 2 hours. She and her roommate had both had their call lights on. The staff			

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	response was to discuss with resident and apologize for delay in care. They informed the resident new staff was being hired and having all staff assist with toileting. There was no documentation of staff education for answering call lights. During an interview, on 1/11/23 at 3:10 p.m., the Nursing Clinical Support Staff indicated there were no call light audits completed. A current policy, titled "Resident Rights Amended Nov 2016," dated as revised 2/15/17 and received from Clinical Support Nurse on 1/4/23 at 1:00 p.m., indicated "...Grievances. The resident has the right to...Voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished; and the behavior of staff and of other residents; and other concerns regarding their LTC facility stay...b. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have...." This Federal tag relates to Complaints IN00390095, IN00381685, IN00381691 and IN00381305. 3.1-3(l)			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent			

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	practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to submit a revised Preadmission Screen and Resident Review (PASARR) Level I after psychotropic medications were prescribed for 1 of 3 residents reviewed for PASARR. (Resident M) Finding includes: The record for Resident M was reviewed on 1/10/23 at 6:30 a.m. Diagnoses included, but were not limited to, dementia unspecified severity without behavioral disturbance, depression, delusional disorder, hypertension, and congestive heart failure. A PASARR level I, dated 2/12/21, indicated the resident did not require a Level II. The resident was taking Sertraline 0.5 mg for depression. A physician's order, dated 5/13/22, indicated divalproex sprinkle (a mood stabilizer medication) 125 mg (milligram) every 8 hours for delusional disorder. A physician's order, dated 5/13/22, indicated	F 0644	Resident M found to be affected by the stated deficient practice with no negative outcomes. 5 Residents have the potential to be affected by the stated deficient practice. Education completed on PASRR policy for SSD and leadership, nurses educated on psychotropic medication. Interdisciplinary team will meet during CCM to discuss changes in psychotropic medication changes. The SSD or designee will review all psychotropic mediation changes and new admissions for 6 months. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus	02/06/2023

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	risperidone (an antipsychotic medication) 0.5 mg (milligram) give 1 tablet by mouth twice a day for delusional disorder. During an interview, on 1/11/23 at 4:34 p.m., the Social Services Director (SSD) indicated the resident was admitted from their Assisted Living and was on divalproex sprinkle and risperidone tablet. A new PASARR should have been completed when the resident started on divalproex and risperidone. During an interview, on 1/12/23 at 3:45 p.m., the Clinical Support Nurse indicated the facility did not have a policy on PASARR. 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		QAPI meetings. The plan will be reviewed and updated as warranted.	
F 0677 SS=E 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 a resident needing assistance with ADLs (activity of daily living) were provided the scheduled daily showers for 6 of 6 residents reviewed for showers. (Resident H, I, L, M, N and O) Finding includes: 1. During an interview, on 1/4/23 at 2:29 p.m., Resident H indicated he needed assistance with ADL care. The resident's showers were scheduled for twice a week. The facility had been short staffed, and the resident had not received a	F 0677	Residents H, I, L, M, N, and O were affected, showers were given. All residents have the potential to be affected. nursing staff educated on shower schedule to be completed. All resident were observed in the facility. All residents audited for bathing preference. As a measure of ongoing	02/06/2023

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	shower in weeks. The record for Resident H was reviewed on 1/6/23 at 10:13 a.m. Diagnoses included, but were not limited to, bipolar disorder, anxiety disorder, chronic obstructive pulmonary disease, post-traumatic stress disorder, and monoplegia (paralysis limited to a single limb). A Profile Care Guide, dated 4/28/22, indicated the resident's showers were scheduled for Wednesday and Saturday on dayshift. The MDS (Minimum Data Set) assessment, dated 10/18/22, indicated the resident was a two-person extensive assist with showers and bathing. An Activity of Daily Living (ADL) report indicated Resident H was missing 20 showers from 10/26/22 through 1/9/23. 2. During an interview, on 1/4/23 at 3:08 p.m., Resident I indicated she had not received a shower in over 3 weeks. The resident did not want a bed bath and was told the staff could not give showers due to being short staffed. The record for Resident I was reviewed on 1/6/23 at 11:45 a.m. Diagnoses included, but were not limited to, Parkinson disease, depressive disorder, delusional disorders, hypertension, hallucinations, and schizoaffective disorder. A profile care guide, dated 4/18/22, indicated the resident's showers were scheduled for Monday and Thursday on dayshift. The MDS assessment, dated 12/23/22, indicated the resident was totally dependent with a 2 person assist for showers and bathing.		compliance, DHS or designee will complete audits to ensure showers have been completed to be monitored for 5 residents 3x weekly for 4 weeks, weekly for 4 weeks, every other week for 4 weeks and monthly for 3 months or until 100 compliance is maintained. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus QAPI meetings. The plan will be reviewed and updated as warranted.	

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	An Activity of Daily Living (ADL) report indicated Resident I did not have a shower from 12/15/22 through 1/5/23. 3. During an observation, on 1/4/23 at 3:28 p.m., Resident L was sitting in the hallway and had a very strong urine odor. The record for Resident L was reviewed on 1/8/23 at 2:30 p.m. Diagnoses included, but were not limited to, dementia, psychotic disturbance, anxiety disorder, mood disturbance, and cognitive communication deficit. A profile care guide, dated 4/18/22, indicated the resident's showers were scheduled for Monday and Thursday on dayshift. The MDS assessment, dated 11/8/22, indicated the resident was a 2-person total assistance with showers and bathing. An Activity of Daily Living (ADL) report indicated Resident I did not have a shower from 11/4/22 through 12/31/22. 4. The record for Resident M was reviewed on 1/10/23 at 6:30 a.m. Diagnoses included, but were not limited to, hypertension, dementia unspecified severity without behavioral disturbance, depression, schizophrenia, and delusional disorder. A profile care guide, dated 3/23/22, indicated the resident's showers were scheduled for Monday and Thursday on dayshift. The MDS assessment, dated 8/18/22, indicated the resident was a 1-person total assist with			

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	showers and bathing. An Activity of Daily Living (ADL) report indicated Resident M did not have a shower from 11/8/22 through 11/25/22. 5. During an interview, on 1/10/23 at 9:12 a.m., Resident N indicated he had not received a shower for one week. He wanted a shower and was told they were short staffed. The record for Resident N was reviewed on 1/9/23 at 3:28 p.m. Diagnoses included, but were not limited to, paraplegia, spina bifida, depressive disorder, anxiety disorder, neuromuscular dysfunction of bladder, and colostomy. The MDS assessment, dated 8/18/22, indicated the resident was a total dependence, 1 person assist with showers and bathing. An Activity of Daily Living (ADL) report indicated Resident N was missing 11 showers from 11/8/22 through 1/6/23. 6. During an observation, on 1/4/23 at 3:42 p.m., Resident O's hair appeared dirty and oily. During an observation, on 1/6/23 at 10:48 a.m., Resident O's hair remained dirty. The resident indicated she did not receive showers. The record for Resident O was reviewed on 1/5/23 at 10:58 a.m. Diagnoses included, but were not limited to, aspiration pneumonia, depressive disorder, anxiety disorder, hypertension, and history of malignant neoplasm of brain (brain tumor). A profile care guide, dated 4/18/22, indicated the			

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	resident's showers were scheduled for Wednesday and Saturday on dayshift. An Activity of Daily Living (ADL) report indicated Resident O was missing 15 showers from 11/2/22 through 1/6/23. During an interview, on 1/4/23 at 3:42 p.m., Resident O indicated she did not get showers and did not want a bed bath. The CRCAs tell the residents they were short staffed. During an interview, on 1/5/23 at 1:00 p.m., CRCA 4 indicated they were very short staffed. They could not get to the residents' showers. During an interview, on 1/9/23 at 4:13 p.m., CRCA 12 indicated the staff hardly had time to do showers, they were very short staffed, and it was hard to get the job done. During an interview, on 1/9/23 at 4:14 p.m., CRCA 13 indicated she could not get her work completed and most days went home upset. During an interview, on 1/10/23 at 9:20 a.m., Resident O indicated she did not have a shower on Saturday. The resident asked for a shower and was told they did not have the staff. During an interview, on 1/10/23 at 11:44 a.m., LPN 3 indicated the residents did not get showers today and they would not get done. They were very short staffed, and the management team said to do the best they could. A current policy, titled "Guidelines for Bathing Preference," dated as revised 5/11/16 and received from the Clinical Support Nurse on 1/9/23 at 10:39 a.m., indicated "...The resident shall determine			

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	their preference for bathing upon admission...Type of bathing - tub bath, bed bath or shower. If the resident is unable to communicate their preference this information shall be obtained from the resident representative based on known history. Bathing shall occur at least twice a week unless resident preference states otherwise...." This Federal tag relates to Complaints IN00381685 and IN00381691. 3.1-38(a)(3)(B) 3.1-38(b)(2)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review and interview, the facility failed to ensure a cognitively impaired resident was provided a preferred activity for 1 of 3 residents reviewed for activities. (Resident 37) Finding includes: During an observation, on 1/4/23 at 3:14 p.m., Resident 37 was sitting up in her Broda chair (for positioning), her television was not on, and she	F 0679	Plant Operations repaired the resident 37 TV on 1/10/23. Staff to ensure Resident's activities of preferences are being followed. All residents have the potential to be affected by the alleged deficient practice.	02/06/2023

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	was looking towards her roommate's television. During an observation, on 1/6/23 at 2:18 p.m., the resident was lying in bed, in her room, and the hospice staff was at the bedside. The resident was looking towards the roommate's television and hers was not on. During an interview, on 1/6/23 at 2:20 p.m., the hospice nurse indicated she did notice the resident was paying attention to the roommate's television and was not sure why the facility staff did not turn the resident's television on. During an observation, on 1/9/23 at 2:26 p.m., the resident was sitting up, in the Broda chair, facing her TV which was turned off. During an observation, on 1/9/23 at 3:43 p.m., the resident was sitting up, in her Broda chair, her head was resting on her left hand. Her television was not on. The record for Resident 37 was reviewed on 1/9/23 at 4:37 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, congestive heart failure, type 2 diabetes mellitus, and major depressive disorder. A care plan, dated 2/11/22 and last updated on 2/13/22, indicated the resident did not care for group activities. The goal included the resident would accept adaptations and modifications to enable participation in activities which were meaningful. The approaches included, but were not limited to, the resident would be provided activities which were meaningful to her including watching television. During an interview, on 1/10/23 at 10:57 a.m., LPN		Audit of all current residents' activity of preferences are up to dated and reflect on their individual care plans. All new admissions and current residents' activity preferences are being honored. The Life Enrichment Director or designee will audit five residents a week for staff support of residents in their choice of activities. The Life Enrichment Director or designee will report findings to QAPI for 6 months or until 100% compliance is maintained.	

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	3 indicated she did not know if the resident's television worked since she did not usually take care of this resident. LPN 3 could not find the remote control for the television and when she turned the TV (television) on with the button on the side, the power came on and no picture. She indicated the facility had changed providers for the TV and she would need to get maintenance to set up the TV service. During an interview, on 1/10/23 at 3:07 p.m., the Life Enrichment Director (LED) indicated she did not know if the resident watched TV in her room. She did like to watch the screen in the hallway which listed resident pictures on it. A current policy, titled "Life Enrichment," dated as reviewed on 6/3/17 and received from the Assistant Director of Health Services on 1/11/23 at 11:05 a.m., indicated "...The Life Enrichment Department designs programs which are meaningful, diverse, stimulating, and consistent with the needs, preferences, and abilities of each individual resident/patient...Programs are designed to provide opportunities for each resident/patient to meet their social, physical, cognitive, and emotional needs and recreation interests...." 3.1-33(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is			

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	unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview and record review, the facility failed to continue to provide a recommended hand splint for a resident with a contracture to the right hand for 1 of 4 residents reviewed for range of motion. (Resident P) Finding includes: The record for Resident P was reviewed on 1/6/23 at 3:18 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, osteoarthritis, pain in the joints of the right hand, and age-related osteoporosis. A physician's order, dated 10/29/21, indicated to apply the splint to the right hand at night and to remove the splint in the a.m. A physician's order, dated 10/29/21, indicated to observe the skin integrity under the splint/brace at bedtime. An OT (occupational therapy) note, dated 11/15/21, indicated the resident had a right hand contracture. An orthotist (a specialist in braces and artificial limbs) was consulted.	F 0688	Resident P was affected with no negative outcomes. Hand splint remains in place as ordered with plan of care current. All residents with hand splints have the potential to be affected. DHS or designee to audit all residents who have hand splints to ensure placement. Nursing staff educated on hand splints administration and placement. Hand splints have been added to care profiles for all qualified staff to utilize and ensure protectors are in place. As a measure of ongoing compliance, DHS or designee will complete audits to ensure splints are being worn and being monitored 3x's weekly for 4 weeks, weekly for 4 weeks, every other week for 4 weeks and monthly for 3 months or until 100 compliance is maintained.	02/06/2023

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	An OT note, dated 11/19/21, indicated the resident's caregivers would demonstrate and verbalize the donning and doffing of the right hand orthotic with 100% accuracy. A care plan, revised on 11/15/22, indicated the resident had a risk for skin breakdown related to the use of a splint/brace at bedtime. During an observation and interview, on 1/10/23 at 10:52 a.m., LPN 3 indicated there was no hand splint in the resident's room and she had never put a hand splint on the resident. The resident had a contracture of the right hand. During an interview, on 1/10/23 at 11:29 a.m., the Clinical Support Nurse indicated the right-hand splint was discontinued in May. During an interview, on 1/11/23 at 10:04 a.m., the ADHS (Assistant Director of Health Services) indicated the facility could not find any documentation on the rationale for the discontinuation of the right-hand splint. There was no information in the progress notes, the OT was not consulted when the splint was discontinued, and the resident was no longer being seen by the OT. The facility did not provide a policy on ROM or the use of orthotics at the time of exit. 3.1-42(a)(2)		As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus QAPI meetings. The plan will be reviewed and updated as warranted.	
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			

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	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 ensure medications were not left unattended for 1 of 3 residents observed for medication administration. (Resident H) Finding includes: During an observation, on 1/4/23 at 2:29 p.m., a medication cup containing one white, one yellow, and one orange pill was found sitting on Resident H's bedside table. The record for Resident H was reviewed on 1/6/23 at 10:13 a.m. Diagnoses included, but were not limited to, bipolar disorder, anxiety disorder, chronic obstructive pulmonary disease, post-traumatic stress disorder, and monoplegia (paralysis limited to a single limb). A physician's order, dated 8/1/22, indicated clonazepam (a controlled substance for anxiety) 0.5 mg (milligrams) tablet give 1 tablet by mouth three times a day. A physician's order, dated 8/1/22, indicated docusate sodium (Colace) (a stool softener) 100 mg capsule give 1 tablet by mouth three times a day. A physician's order, dated 9/21/22, indicated divalproex (Depakote) (used to treat bipolar disorder) delayed release 250 mg tablet give 1 tablet by mouth three times a day.	F 0689	Resident H was affected with no negative outcomes. Resident remains free of psychosocial distress. Resident continues activities of daily living as expected per baseline. All residents have the ability to be affected. DHS or designee to review residents who have the ability to self-administer medication. Education completed with medication passers on proper medication administration. As a measure of ongoing compliance, DHS or designee will complete audits on residents with no self-administration to have meds taken in front of licensed staff member to be monitored for 5 residents 3x weekly for 4 weeks, weekly for 4 weeks, every other week for 4 weeks and monthly for 3 months or until 100 compliance is maintained. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until	02/06/2023

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	There was no physician's order or care plan to self-administer medication. During an interview, on 1/4/23 at 2:35 p.m., LPN 3 indicated she placed the pills on the bedside table and left the room. The medications in the cup were Depakote, clonazepam, and Colace. The medication was not supposed to be left at the bedside. During an interview, on 1/4/23 at 3:48 a.m., the Administrator indicated pills were not to be left at the bedside unattended. During an interview, on 1/9/23 at 10:36 a.m., the Clinical Support Nurse indicated the resident must be alert and oriented and have a care plan to self-medicate. A current policy, titled "Specific Medication Administration Procedures," dated as revised 11/18 and received by the Administrator on 1/6/23 at 10:44 a.m., indicated "...To administer in a safe and effective manner...Security: All medication storage areas (carts, medication rooms, central supply) are locked at all times unless in use and under the direct observation of the medication administration personnel... After administration, return to cart, replace medication container (if multi-dose and doses remain), and document administration in the MAR or TAR, and controlled substance sign out record, if indicated...Monitor for side effects or adverse drug reactions immediately after administration and throughout each shift...." 3.1-45(a)(2)		campus achieves one hundred percent compliance in the campus QAPI meetings. The plan will be reviewed and updated as warranted.	

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure a resident was started on the bowel protocol and to ensure an incontinent	F 0690	Resident O and L were affected with no negative outcomes. Bowel protocol put in place for residents	02/06/2023

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	resident was changed for 2 of 2 residents observed for bowel and bladder. (Resident O and L) Findings include: 1. During an interview, on 1/4/23 at 3:42 p.m., Resident O indicated she was incontinent of bowel and bladder. She was constipated and had not had a bowel movement (BM) in days. The record for Resident O was reviewed on 1/5/23 at 10:58 a.m. Diagnoses included, but where not limited to, aspiration pneumonia, depressive disorder, anxiety disorder, hypertension, and history of malignant neoplasm of brain (brain tumor). A physician's order, dated 3/22/22, indicated the resident may utilize the facility bowel protocol as needed. A physician's order, dated 7/4/22, indicated to give Colace (a bowel softener) 1 capsule two times a day when needed. A Profile Care Guide, dated 4/18/22, indicated the resident was incontinent of bowel and bladder. A Care Plan, dated 4/1/22, indicated Resident O had an impairment in functional status and was an extensive assist with toileting An Intake & Output Report indicated the resident did not have a bowel movement in 12 days from 12/2/22 through 12/14/22. A Certified Resident Care Associate job description, dated 10/09, indicated the CRCA was responsible to assist residents to the bathroom, to		and care was provided to incontinent residents. All residents have the ability to be affected. DHS or designee to ensure bowel protocol is in place for all residents and care provided to incontinent residents per preference and to meet the resident's needs. All nursing staff in-serviced by the ED and DHS on ADLS care for bowel protocol and changing of incontinent residents. As a measure of ongoing compliance, the ED, DHS or designee will review bowel documentation for 3x weekly for 4 weeks, weekly for 4 weeks, every other week for 4 weeks and monthly for 3 months; mointor for incontinent care for 5 residents a week for 3x weekly for 4 weeks, weekly for 4 weeks, every other week for 4 weeks and monthly for 3 months or until 100 compliance is maintained.	

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	maintain intake and output records as instructed, and to check and report bowel movements and character of stools. The Medication Administration Record (MAR) indicated Colace 100 mg capsule was given one time from 12/1/22 through 1/9/23. During an interview, on 1/10/23 at 10:05 a.m., the Assistant Director of Health Services (ADHS) indicated the CRCAs were responsible to chart when an incontinent resident had a BM. The residents were started on the Bowel Protocol when admitted. During an interview, on 1/10/23 at 10:20 a.m., CRCA 8 indicated when an incontinent resident had a bowel movement, they charted the bowel movement. The policy was if a bowel movement was not charted the resident did not have one. 2. During an observation, on 1/4/23 at 3:28 p.m., Resident L was sitting in the hallway and had a very strong urine odor. During an observation, on 1/6/23 at 2:55 p.m., the resident's room had a strong urine odor and the odor continued out into the hallway. During an observation, on 1/10/23 at 9:14 a.m., CRCA 4 and CRCA 6 were providing incontinent care for the resident. The CRCAs entered the room and indicated the room had a very strong odor. CRCA 4 indicated the room had a very strong urine odor and normally did. CRCA 4 could not get to the resident as often as she should because they were so shorted staff. They were supposed to check residents every two hours and they did not. The resident was last checked around 4:30 a.m., on the nightshift. CRCA 4 pulled			

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	down the blanket and the residents brief appeared wet. The resident's peri area was very red. The resident was turned over and a patch was on the resident's coccyx dated 1/10/23. The resident's buttocks between the cheeks were red. The record for Resident L was reviewed on 1/8/23 at 2:30 p.m. Diagnoses included, but were not limited to, dementia, psychotic disturbance, anxiety disorder, mood disturbance, and cognitive communication deficit. A Care Plan, dated 7/15/19, indicated Resident L had impairment in functional status and was an extensive 2 person assist with toileting. A Care Plan, dated 7/15/19, indicated Resident L experienced episodes of incontinence and needed assistance with toileting needs. During an interview, on 1/6/23 at 3:03 p.m., the Assistant Director of Health Services (ADHS) indicated the resident's room had a very offensive odor, she searched the room and did not find any dirty briefs. She indicated the room had a smell and she would have to find out why. During an interview, on 1/11/23 at 12:21 p.m., the Director of Health Services (DHS) indicated the residents should be checked on every 2 hours if not hourly and incontinent residents needed changed at the time, they were found incontinent. A current policy, titled "Bowel Protocol Guideline," dated as revised 11/9/17 and received from the Clinical Support Nurse on 1/9/23 at 10:00 a.m., indicated "...To provide guidance for the use of bowel stimulants for residents with constipation. Upon admission, an order may be obtained to 'Utilize Bowel Protocol as needed' If			

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	the resident needs to utilize the bowel protocol, the 'Bowel Protocol' order set may be opened, and orders entered from order set. The Ineffective Bowel Pattern Event should be initiated for any resident not having a BM with 72 hours (unless this has been determined to be a usual bowel pattern for the individual). A progress note associated to the Ineffective Bowel Event, should be completed until the resident has a BM or the bowel pattern returns to normal for the resident. The progress note should include abdominal distention, pain and bowel sounds...." This Federal tag relates to Complaints IN00381685 and IN00381691. 3.1-38(a)(2)(C) 3.1-42(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to obtain a physician's order for the use of oxygen (02) and to clarify the exact liter flow level for the 02 for 1 of 2 residents reviewed for 02 use. (Resident 6) Finding includes:	F 0695	Resident 5 was affected with no negative outcomes. Oxygen orders placed per MD order with liter flow. All resident with oxygen have the ability to be affected. DHS or	02/06/2023

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	During an observation, on 1/4/23 at 3:28 p.m., Resident 6 was lying in bed, in her room, and had 02 on at 3L/M (three liters per minute) by nasal cannula (NC). During an observation, on 1/6/23 at 2:25 p.m., the resident was lying in bed, in her room, with 02 per NC in place. During an observation, on 1/9/23 at 3:35 p.m., the resident was sitting up, in a wheelchair, in the common area close to the nurse's desk and had 02 per NC in place. The record for Resident 6 was reviewed on 1/6/23 at 11:42 a.m. Diagnoses included, but were not limited to, influenza A, chronic obstructive pulmonary disease, chronic respiratory failure, malignant neoplasm of the lung, and pneumonia. A care plan, dated 8/28/2019 and last revised on 1/5/23, indicated the resident had a potential for shortness of breath while lying flat and required supplemental 02 to maintain 02 saturations. The approaches included to administer 02 per the physician's order. A progress note, dated 12/19/22 at 11:16 a.m., indicated the resident requested to be transported to the emergency department due to feeling like she had pneumonia. The resident had a low-grade temperature and a cough. The resident was transported by EMS (emergency medical services). A progress note, dated 12/25/22 at 1:11 p.m., indicated the resident returned from the hospital and had oxygen at 2L per NC. A progress note, dated 12/28/22 at 1:48 p.m.,		designee to audit all new admissions for oxygen orders with liter flow. All nursing staff educated on following MD orders with oxygen and correct liter flow. As a measure of ongoing compliance DHS or designee will audit 5 charts weekly for 4 weeks, 3 charts weekly for 4 weeks, 1 chart weekly for 4 weeks then monthly to ensure that orders are in correctly or until 100% compliance has been maintained.	

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	indicated the resident had course lung sounds and 02 at 2L. A progress note, dated 12/30/22 at 2:31 a.m., indicated the resident had on 02 at 2L continuous. A progress note, dated 1/1/23 at 8:00 a.m., indicated the resident's initial 02 check was 89%. The resident was lying down almost flat in bed. The head of bed was elevated and the 02 was increased to 3L. The recheck was 93%. The notes did not include the physician was notified of the need to increase the 02 to 3L. A physician's order, dated 1/5/23, indicated oxygen at 2L per nasal cannula continuous. May titrate to keep oxygen above 93%. The physician's order was not entered until 1/5/23 and the order did not include the number of liters per minute the 02 could be titrated. The resident had 02 from 12/25/22 through 1/5/23 without an order. During an interview, on 1/6/23 at 12:25 p.m., the Clinical Support ED (Executive Director) indicated he was not aware the physician's order for the resident's oxygen did not get entered into the electronic health record until 1/5/23. He would need to talk to the DHS (Director of Health Services). During an interview, on 1/6/23 at 2:29 p.m., the Clinical Support Nurse indicated the admitting nurse would be responsible to obtain and enter the physician's order for the 02 into the EHR. The resident returned from the hospital on 12/25/22 and she did not know the reason the 02 orders did not get obtained until 1/5/23. The order should			

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	include a set number of liters and if the 02 was continuous or just at night. During an interview, on 1/9/23 at 4:08 p.m., the Clinical Support Nurse indicated the physician's orders for the 02 did not include the parameters for the liter flow to keep the 02 saturation at 93% or above and should have included the parameters. A current policy, titled "Administration of Oxygen," dated as reviewed on 12/1/21 and received from the Clinical Support Nurse on 1/6/23 at 3:24 p.m., indicated "...Guidelines to properly Administering Oxygen and any Respiratory procedure...Verify physician's order for the procedure...In cases of emergency oxygen may be administered as a nursing intervention unit a physician order may be obtained...Oxygen setting must be set and adjusted by a licensed nurse...Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute...Place appropriate oxygen device on the resident...If more the 4L of oxygen is needed the resident should receive liquid oxygen rather than use a concentrator...." 3.1-47(a)(6)			
F 0725 SS=F Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and			

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	considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.			
	Based on observation, interview and record review, the facility failed to ensure enough staff were available to check on call light response times, to staff CNAs according to the Facility Assessment plan, to complete resident baths and showers, to check and change incontinent residents every 2 hours, and to observe medication administration. This deficient practice had the potential to affect 56 of 56 residents residing in the facility. Findings include: 1. During an interview, on 1/4/23 at 3:21 p.m., Resident T indicated it took one hour to get staff to answer her call light. During an interview, on 1/4/23 at 3:34 p.m., Resident K indicated the facility had staffing issues due to illnesses with covid and the flu.	F 0725	All residents have the ability to be affected with no negative outcomes. All residents have the ability to be affected. Call lights have been reviewed and resident call lights are being answered appropriately. Staff personnel will be in-serviced on guidelines for answering call lights timely and to seek assistance from leadership staff. As a measure of ongoing compliance ED or designee will audit call light response times 5 times a week for 4 weeks, 3 times	02/06/2023

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	During an interview, on 1/4/23 at 4:43 p.m., Resident U indicated it took a long time to get help and he wasn't sure his call light was working correctly. During the resident council meeting, on 1/6/23 at 2:48 p.m., the residents indicated it took a long time to get call lights answered and the staff would say they are short staffed of CNAs and nurses. The residents would find the staff standing at the nurse's station and it would take 45 minutes to one hour and sometimes 2 hours to get help at times. One resident indicated she had to complain 3 times before she got a shower and was not always getting 2 showers a week. During an anonymous staff interview, on 1/9/23 at 2:14 p.m., the staff indicated on most days there were only 2 CNAs for the entire 500 hall for 42 residents. The residents' showers were a hit and miss and the "squeaky wheel" would get showers and the ones who didn't complain did not get showers as often. The CNAs would not stay here when they realized how much work it was going to be with just 2 CNAs for the unit. There had been some nurses who left employment. There had also been staff illness with the flu and other things, so this had not helped with staffing. During an interview, on 1/11/23 at 11:00 a.m., the DHS (Director of Health Services) indicated the as-worked staffing schedules did not include what unit the CNAs were assigned to work. The facility staffed 2 CNAs for the 500 hall and one CNA for the 300 and 400 halls for a total of 3 CNAs for the shift. The facility was not staffing with 13 CNAs per day as listed on the Facility Assessment for the average daily census of 55. The facility staffed with 9 or less CNAs per 24 hours. The census for the survey was 56. She was aware residents had		a week for 4 weeks, monthly for 3 months or untill 100% compliance has been maintained.	

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	grievances about call light response times and since she started working at the facility, in October of 2022, there had not been a call light audit completed. 2. The facility failed to ensure 6 out of 6 residents who required assistance received scheduled showers. a. Resident H was missing 20 showers from 10/26/22 through 1/9/23. b. Resident I did not receive a shower from 12/15/22 through 1/5/23. c. Resident L did not receive a shower from 11/4/22 through 12/31/22. d. Resident M did not receive a shower from 11/8/22 through 11/25/22 e. Resident N was missing 11 showers from 11/8/22 through 1/6/23 f. Resident O was missing 15 showers from 11/2/22 through 1/6/23. 3. During an observation, on 1/6/23 at 2:55 p.m., Resident L's room had a strong odor of urine, and the odor could be smelled in the hallway. During an interview, on 1/10/23 at 9:40 a.m., CRCA 4 indicated Resident L was supposed to be checked for incontinence every 2 hours although she had not been checked for 5 hours. There was a strong odor of urine in the room. The facility was short staffed and CRCA 4 did not have time to check the resident every 2 hours. 4. A facility grievance form, dated 6/13/22, indicated the staff was leaving medications on their tables. During an observation, on 1/4/23 at 2:29 p.m., a medication cup containing one white, one yellow, and one orange pill was found siting on Resident			

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	H's bedside table. During an interview, on 1/4/23 at 2:35 p.m., LPN 3 indicated she placed the pills on the bedside table and left the room. During an interview, on 1/11/23 at 11:07 a.m., the DHS indicated the facility had several team members who left employment and they were trying to recruit new staff on an ongoing basis. The staff were supposed to float to assist with showers and the staff needed to work as a team. The staff were marking showers as refused which did not coincide with the resident concern forms. The staff were instructed not to mark a shower as refused unless they talked to a nurse. She was not aware of the strong urine odor in the 500 hall. A current policy, titled "Resident Rights," last reviewed on 12/1/21 and received from the Executive Director on 1/4/23 at 1:00 p.m., indicated "...This facility will inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility...The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility...The right to participate in the development of his or her person-centered plan of care, including but not limited to....the type, amount and frequency, and duration of care...The right to receive the services and/or items in the plan of care...The right to reside and receive services in the facility with reasonable accommodation of the resident needs and preferences...The resident has the right to...Voice grievances to the facility or other agency or entity that hears grievances without discrimination or			

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	reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished...the behavior of staff and of other residents...other concerns regarding their LTC facility stay...." This Federal tag relates to Complaints IN00390095, IN00381691, IN00381305 and IN00381685 3.1-17(a) 3.1-17(b)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to			

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	residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview and record review, the facility failed to have nurse staffing posted where it could easily be viewed and failed to have the staffing posted correctly for 5 of the 7 days during the survey. (January 4, 5, 6, 9 and 10) Finding includes: During ongoing observations, between 1/4/23 and 1/10/23, the surveyors could not locate the posted nurse staffing. During an interview, on 1/10/23 at 2:08 p.m., the ED (Executive Director) indicated the nurse staffing was posted on the 400 hallway just outside the DHS (Director of Health Services) office. The staffing was posted in a corner of the wall where it was not visible while walking down the hallway. The ED was not aware the staffing should be visible to all visitors and should include the exact staff hours worked. The staffing did not show exactly how many staff were working and the exact hours each staff worked. The facility had some staff who worked 8-hour shifts and some staff who worked 12-hour shifts and the posted staffing did not indicate	F 0732	There were no residents found to be affected by the stated deficient practice. 100% of the residents have the potential to be affected by the stated deficient practice. An in-service will be conducted for the nursing staff/leadership staff regarding minimal staffing requirements per State of Indiana guidelines. The Daily Staffing Information (Benefits Improvement and Protection Act) form will be reviewed by acting leadership daily and ensure accuracy. Announcement holder was placed at the front entrance/guest relations desk to hold the paperwork. Audits will be conducted at a rate of 5 times a week for 4 weeks, 3	02/06/2023

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	this. A current policy, titled "Guidelines for Staff Posting," dated as reviewed on 12/01/2021 and received from the Assistant Director of Health Services on 1/11/23 at 11:05 a.m., indicated "...To ensure compliance with federal regulations requiring posting on a daily basis for each shift, the number of nursing personnel responsible for providing direct resident care...At the beginning of the day the number and amount of hours of licensed nurses [RN and LPN] and the number and hours of unlicensed nursing personnel, per shift, who provide direct care to residents will be posted...Handwritten numbers must be legibly printed in black ink...and should be easily seen and read by residents, staff, visitors and others who are interested in our campus daily staffing information...Staffing sheets should be posted in a common area easily visible upon entry to the campus...." 3.1-17(b)		times a week for 4 weeks, 2 times a week for 4 weeks, weekly for 4 weeks and monthly for 2 months. The results of the audits will be documented on an audit form initiated by the facility and reported, reviewed, and trended for compliance through the campus QAPI Committee for a minimum of 6 months then randomly thereafter for further recommendations.	
F 0760 SS=G Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure pain patches were monitored for placement and to change an order received from a hospital discharge for 1 of 5 residents reviewed for medication errors. (Resident E). Resident E was admitted to the hospital due to a change in mental condition. Finding includes: 1. A Facility Incident Report, dated 11/3/22 at 6:20	F 0760	Resident E was affected with no negative outcomes. Orders placed for 2 staff members to check placement of fentanyl patches. All resident with fentanyl patches have the ability to be affected. Head to toe assessments completed to ensure resident has only 1 patch on person. Orders	02/06/2023

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	p.m., indicated the resident displayed a change in condition. When the nurse assessed Resident E, two fentanyl 37.5 mcg (microgram) patches (a pain patch apply to the skin) were discovered on the resident's chest. On the right side the patch was dated 10/30/22, and on the left side the patch was dated 11/2/22. The record for Resident E was reviewed on 1/9/23 at 4:21 p.m. Diagnoses included, but were not limited to, altered mental status, depressive disorder, anxiety disorder, nonpsychotic mental disorder, and cognitive communication deficit. A progress note, dated 11/3/22 at 6:20 p.m., indicated the nurse entered the room and noticed the resident had her eyes closed and was hard to arouse. An assessment was completed on the resident and two Fentanyl 37.5 mcg/hr patches were found on the resident's upper chest. The patches were dated 10/30/22 and 11/2/22. A progress note, dated 11/03/2022 at 8:00 p.m., indicated a new order for Narcan 0.4 mg (milligram) Intramuscular (IM) was administered and the resident was transferred to the Emergency Department. An Emergency Department report, dated 11/3/22, indicated the resident presented with respiratory distress. The resident was found with two fentanyl 37.5 mcg patches. During an interview, on 1/5/23 at 10:15 a.m., Resident E's family member indicated they received a call from the nurse informing them the resident was going to the hospital. The nurse thought the resident had too much Fentanyl. During an interview, on 1/10/23 at 11:06 a.m., the		placed for placement of patch by 2 facility staff members. Nurses and medication passers have been educated on ensuring only 1 patch on resident and that the Dr. is notified upon admission/readmission to verify orders. As a measure of ongoing compliance ED or designee will audit patch placement and admission/readmission audit for 5 residents weekly for 4 weeks, 5 residents every other week for 4 weeks, 5 residents monthly for 4 months or until 100% compliance has been maintained. The results of the audits will be documented on an audit form initiated by the facility and reported, reviewed, and trended for compliance through the campus QAPI Committee for a minimum of 6 months then randomly thereafter for further recommendations.	

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	Administrator indicated the resident had two fentanyl patches. The nurse found the resident with her eyes closed and she was hard to arouse. The nurse completed an assessment on the resident. There were two fentanyl 35 mcg/hr patches on her chest. The nurse notified the physician and family. The nurse gave Narcan 0.4 mg IM and the resident was sent to the emergency room. During an interview, on 1/10/23 at 11:44 a.m., LPN 3 indicated the nurses were now supposed to double check the placement of a fentanyl patches and the site with two staff members. 2. The resident returned from the hospital on 11/4/22 with a new order to discontinue the current fentanyl 37.5 mcg/hr patch and start fentanyl 25 mcg/hr applied every 72 hours. A Medication Administration Record (MAR) indicated fentanyl 37.5 mcg/hr was given on 11/15, 11/18, 11/21, 11/24, 11/27, 11/30, 12/3, 12/6, 12/9, 12/12, 12/15, 12/18, 12/21, 12/24, 12/27, 12/30/22 and 1/2, 1/5, 1/8 and 1/11/23. The resident was administered the incorrect dosage of fentanyl 37.5 mcg for 10 weeks. During an interview, on 1/11/23 at 2:16 p.m., the Clinical Support Nurse indicated the resident's hospital discharge order from 11/4/22 was to discontinue previous order for fentanyl 37.5 mcg and replace it with 25 mcg/hr every 72 hours. The order was not put in correctly. A current policy, titled "Specific Medication Administration Procedures," dated as revised 11/18 and received by the Administrator on 1/6/23 at 10:44 a.m., indicated "...To administer medications in a safe and effective manner...After			

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	administration, return to cart, replace medication container...and document administration in the MAR or TAR, and controlled substance sign out record, if indicated. Monitor for side effects or adverse drug reactions immediately after administration and throughout each shift...Notification of Physician/Prescriber...Suspected adverse drug reactions...." A current policy, titled "Guidelines for Medication Error Reporting." undated and received by the Clinical Support Nurse on 1/11/23 at 3:17 p.m., indicated "...To identify medications given in error and expedite correction actions...In the event of a medication error, nursing personnel should first take whatever immediate action is necessary to protect the resident's safety and welfare. Notify the attending physician promptly of the error. Implement physician's orders. Notify the resident or responsible party. Initiate the appropriate Event form. Monitor the resident closely for 72 hours or as directed. Document the following in the resident's clinical record. A description of the error (brief). Name of physician and time notified. Physician's subsequent orders. Medication errors will be reviewed by the Quality Assurance Committee to identify trends and/or actions for implementations...." 3.1-48(c)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when			

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	applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation and interview, the facility failed to dispose of loose pills, refrigerate an unopened insulin pen and to dispose of a compromised controlled substance for 2 of 6 carts reviewed for medication storage. (500 front and 500 back cart) Findings include: 1. During an observation, on 1/9/23 at 3:30 p.m., Cart 500 back had the following: a. seven and a half unidentified loose pills in the second drawer. b. A card of Tylenol #3 (a controlled pain medication) 300-30 mg (milligram) for Resident 4 with the covering on slot 4 torn and the pill was exposed. c. An unopened Lantus pen (for diabetes mellitus) with a label to refrigerate if unopened in the top	F 0761	No residents were affected per 2567. DHS or designee completed cart reviews to ensure medications are not loose in the cart, insulin pens are dated and controlled substances are discarded correctly. All resident have the ability to be affected. All medication carts will be audited to ensure proper storage and disposal of medication. Nursing staff educated on proper medication storage and disposal of controlled substance	02/06/2023

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	155290	A. BUILDING 00 B. WING	01/12/2023

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	drawer for Resident 157. 2. During an observation, on 1/11/23 at 9:45 a.m., Cart 500 front had two unidentified loose pills in the bottom of the second drawer. During an interview, on 1/9/23 at 3:30 p.m., the Certified Resident Medication Assistant (CRMA) 10 counted seven and a half unidentified loose pills in the 500 back cart and indicated she did not look on the back of the narcotic cards when counting the narcotics. During an interview, on 1/9/23 at 4:18 p.m., the Director of Health Services (DHS) indicated there should not be loose pills in the medication cart and the staff could not see the Tylenol #3 card was torn by looking from the front of the card. During an interview, on 1/11/23 at 9:45 a.m., RN 11 indicated there should not be pills loose in the bottom of the drawers. They should be destroyed in the drug buster locked in the medication rooms. A current policy, titled "Medication Storage and Labeling," undated and received from the Clinical Support Nurse on 1/12/23 at 3:45 p.m., indicated "...To administer in a safe and effective manner...Security: All medication storage areas (carts, medication rooms, central supply) are locked at all times unless in use and under the direct observation of the medication administration personnel...Secured (locked) locations, accessible only to designated staff; clean and sanitary conditions...." 3.1-25(o)		guidelines. As a measure of ongoing compliance ED or designee will audit 1 medication cart 3 times a week for 4 weeks, weekly for 4 weeks, monthly for 4 months or until 100% compliance has been maintained. The results of the audits will be documented on an audit form initiated by the facility and reported, reviewed, and trended for compliance through the campus QAPI Committee for a minimum of 6 months then randomly thereafter for further recommendations.	
F 0812 SS=D	483.60(i)(1)(2) Food			

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Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on record review, interview and observation, the facility failed to serve food at appropriate temperatures for 4 of 4 residents reviewed for food at appropriate temperatures. (Residents Q, R, S and G) Findings include: During the resident council interview, on 1/6/23 at 2:48 p.m., Resident's Q, R, and S indicated the food was cold when it was served, especially when served to the residents' room. During an interview, on 1/5/23 at 12:47 p.m., Resident G indicated the food did not taste good at all and was served cold with no flavor.	F 0812	1oo% of the residents have the potential to be affected by the stated deficient practice. All foods that were allegedly not up to temperature were discarded. The Dietary Manager conducted an observation of food storage and that proper handling and storage to ensure proper temperature is maintained while distributing meal trays. An in-service was conducted for the dietary staff with focus on policy an dprocedure related to food storage and temperatures.	02/06/2023

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	During an interview, on 1/6/23 at 9:55 a.m., Resident G complained of the breakfast being cold. During an interview, on 1/9/23 at 12:15 p.m., Resident G indicated the food was cold and horrible over the weekend and the trays came out late. On resident concern form, dated 2/14/22, a resident indicated the food was cold. The response from the dietary manager indicated for the staff to always make sure the resident's food was hot and when the resident did not come to the dining room, he could not always control the temperatures. The resident council meeting minutes, dated 5/9/22 at 10:00 a.m., indicated things had not been resolved. Residents indicated they would like the food warmer. The response from the dietary manager was to talk to residents and staff to make sure the plate warmers were being used, food temperatures were being taken by staff, and to follow up with residents after meals. The resident council meeting minutes, dated 6/13/22 at 10:30 a.m., indicated the food was still cold sometimes. During the kitchen walk-through, on 1/5/23 at 11:40 a.m., the Dietary Manager checked the temperature of the main meal item, pizza, and the temperature was 140 degrees Fahrenheit. The salad sitting on the counter in the kitchen next to the service window had a temperature of 63 degrees Fahrenheit. During an interview, on 1/5/23 at 11:45 a.m., the Dietary Manager indicated the salad temperatures		The Dietary Manager or designee will conduct random audits of food storage to ensure that food is stored in a safe and maintaining proper temperatures. The stated audits will be conducted at a rate of 2 times a week for 4 weeks, every other week for 4 weeks, monthly for 4 months or until 100% compliance has been maintained. The results of the audits will be documented on an audit form initiated by the facility and reported, reviewed, and trended for compliance through the campus QAPI Committee for a minimum of 6 months then randomly thereafter for further recommendations.	

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	were too high and the pizza should have been 145 degrees Fahrenheit. During an observation of the room tray service, on 1/5/23 at 12:56 p.m., the tray service started with the cart temperature for cold foods at 31 degrees Fahrenheit and for the hot foods the cart temperature was 195 degrees Fahrenheit. The last tray served was at 1:20 p.m., and the pizza on the tray had a temperature of 120 degrees Fahrenheit and the applesauce for dessert was 52 degrees Fahrenheit. During an interview, on 1/5/23 at 1:25 p.m., the Dietary Manager indicated the applesauce was at room temperature because a new container was opened and was served immediately. The temperature for the pizza should have been 145 degrees Fahrenheit to serve. During an interview, on 1/5/23 at 12:22 p.m., LPN 3 indicated the room trays were delivered at various times and she did not know if the food was warm. A current publication, titled "Nutrition In-Service Manual," dated 2010, indicated "...hot food must be kept at 135 degrees Fahrenheit or above...cold food must be kept at 41 degrees Fahrenheit or below...bacteria in food can multiply and cause food born illness or death for the geriatric population...." A current policy, titled "Hot & Cold Temperature Holding Guidelines," undated and received from the Administrator on 1/5/23 at 1:05 p.m., indicated "...The temperature of all foods on the serving line will be measured prior to resident service and recorded at every meal...Hot food in the steam table should be at least 135 or higher degrees Fahrenheit and arrive approximately at greater			

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	than or equal to 120 degrees Fahrenheit when the resident is served. This is a guideline as certain foods like hot breads and eggs will not be this hot...Cold foods should be 40 degrees or less when the temperature is taken in the kitchen at the time of services...Thermometers should be in all refrigerators, freezers, and storage areas...There should be immediate follow-up on refrigerator and freezer temperatures deviations to correct the problem. (Exception-when the freezer is on the automatic defrost cycle...." This Federal Tag relates to Complaint IN00390095. 3.1-21(i)(1) 3.1-21(i)(2) 3.1-21(i)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized			

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	§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and			

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	services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observation, record review and interview, the facility failed to accurately document whether a splint was utilized for a resident's right-hand contracture for 1 of 4 residents reviewed for range of motion. (Resident P) Finding includes: The record for Resident P was reviewed on 1/6/23 at 3:18 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, osteoarthritis, pain in joints of the right hand, and age-related osteoporosis. A physician's order, dated 10/29/21, indicated to observe the skin integrity under the splint/brace at bedtime. The physician's order did not include what type of splint/brace or where the brace would be located. An OT (occupational therapy) note, dated 11/15/21, indicated the resident had a right hand contracture. An orthotist (a specialist in braces and artificial limbs) was consulted. A care plan, revised on 11/15/22, indicated the resident had a risk for skin breakdown related to the use of a splint/brace at bedtime. The care plan did not indicate the type of	F 0842	Resident P was affected with no negative outcomes. Occupational therapy to assess resident for need for hand splint. MD orders obtained. All resident with hand splints have the ability to be affected. All residents with hand splints will be reviewed for proper assessment, interventions, and care plan. Licensed nursing staff educated on properly documenting on hand splints. As a measure of ongoing compliance, hand splints will be audited for 5 residents weekly for 4 weeks, 5 residents every other week for 4 weeks, 5 residents monthly for 4 months or until 100% compliance has been maintained. The results of the audits will be documented on an audit form initiated by the facility and reported, reviewed, and trended for compliance through the campus QAPI Committee for a	02/06/2023

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	splint/brace. During an observation, on 1/10/23 at 10:52 a.m., LPN 3 indicated there was no hand splint in the resident's room and she had never put a hand splint on the resident. The resident had a contracture of the right hand. During an interview, on 1/10/23 at 11:29 a.m., the Clinical Support Nurse indicated the order to check the skin under the splint each night should have been discontinued when the splint was discontinued. The current documentation was not correct. The facility had not provided a policy on documentation prior to exit. This Federal tag relates to Complaint IN00381305. 3.1-50(a)(2)		minimum of 6 months then randomly thereafter for further recommendations.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure residents' rooms were free of soiled linens, soiled briefs, gouged and unpainted doorways, strong odors, and missing furniture handles for 8 of 29 rooms on the 500 hall. (Rooms 504, 505, 506, 512, 507, 510, 517 and 519). Findings include: 1. During an observation, on 1/4/23 at 2:30 p.m., Room 504 had a clear plastic trash bag of soiled	F 0921	None of the residents residing on the 500 hall: including residents in rooms 504, 505, 506, 507, 510, 512, 517, 519, as well as Resident D or Resident R, had any ill effects due to this alleged deficient practice. All staff have been educated on room cleanliness standards. All rooms have been audited for cleanliness. Residents room 506, 512, 507, 510 gauges in wall/trim/doors have been	02/06/2023

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	clothes on the bathroom floor. There was a used clear bandage with a white center laying on the bathroom floor next to the trash can. The bottom third of the bathroom door trim had gouging and was painted over the gouges. During an interview, on 1/4/23 at 2:34 p.m., RN 14 indicated soiled clothing was not usually left on the bathroom floor. 2. During an observation, on 1/4/23 at 2:37 p.m., Room 505 had a brief soiled with BM (bowel movement) on the floor next to the toilet. The toilet was filled with BM. The trim on the bathroom door had gouging and missing paint on the lower part up to where the doorknob was located. The edge of the door had gouging and missing paint and there was plaster on the floor noted at the entrance to the bathroom. 3. During an observation, on 1/4/23 at 2:56 p.m., Room 506 bathroom door trim had gouging on the lower 1/4 of the trim. The trim was painted although the gouging was still visible. 4. During an observation, on 1/4/23 at 3:22 p.m., Room 512 bathroom door had gouging all over on the inside and outside of the bathroom. 5. During an observation, on 1/5/23 at 11:22 am, Room 507 bathroom door trim had gouging and missing paint and about halfway up the door there was a large gouge about 12 inches long with missing paint. 6. During an observation, on 1/5/23 at 1:08 p.m., Room 510 had gouging and missing paint all around the bathroom door frame.7. During an observation, on 1/6/23 at 2:55 p.m., Room 517 had a horrible urine odor, and the odor went out into		repaired. Residents room 505 scrape on the bottom wall has been repaired. Room 517 foul odor has been placed on the books with an outside company. Resident D dresser knobs have been repaired/replaced. All residents have the potential to be affected by this alleged deficient practice. DPO or designee will conduct an inspection to be completed on all residents' rooms to ensure rooms are in good repair. All residents have the potential to be affected by this alleged deficient practice. ED or designee will conduct an: Inspection to be completed on all residents' rooms to ensure rooms, are in good repair and inspection of all residents rooms to ensure a cleanly fashion is maintained. ED or designee will re-educate all staff and IDT on the following campus guideline: Maintaining rooms and Work orders As a measure of ongoing compliance ED or designee will audit 5 rooms a week for 4 weeks, 5 rooms every other week for 4 weeks, and then 5 rooms a month for 4 months or until 100% compliance has been maintained. The results of the audits will be documented on an audit form	

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	the hallway. During an observation and interview, on 1/6/23 at 3:03 p.m., the Assistant Director of Health Services (ADHS) went into Room 517 and indicated the room had an offensive odor. The ADHS searched the room and did not find any dirty briefs in the trash cans. The ADHS indicated the room had a smell and she would have to find out why. During an interview, on 1/6/23 at 3:05 p.m., Housekeeping 7 noticed the smell on 1/5/23 and could not locate why. During an interview, on 1/09/23 at 9:43 a.m., Resident D's family member indicated there had been a horrible odor in the 500 hallway for a while and it smelled like urine. During an interview, on 1/10/23 at 9:14 a.m., CRCA 4 and CRCA 6 were providing incontinence care for Resident R. Resident R's room on the 500 hallway had a very strong odor. The CRCAs indicated the room had a very strong urine odor and normally did due to both residents in room were "heavy wetter's". 8. During an observation, on 1/10/23 at 9:01 a.m., Resident D's dresser had four drawers. The two knob drawers were missing one knob on each drawer. During an interview, on 1/10/23 at 9:08 a.m., the Maintenance Support indicated he was aware the knobs on several dressers were missing. They were replacing them as they got to them. During an interview, on 1/5/23 at 1:10 p.m., Maintenance Clinical Support 9 indicated the		initiated by the facility and reported, reviewed, and trended for compliance through the campus QAPI Committee for a minimum of 6 months then randomly thereafter for further recommendations.	

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	facility was going to hold a maintenance "blitz" where staff from other facilities would come in and paint. This happened twice a year. The building was also due for renovations in the future and the trim around the doors would be replaced then. During an interview, on 1/11/23 at 4:55 p.m., the ED (Executive Director) indicated the corporate office had a plan for renovating the facility although they did not want to send the plan or the dates of the renovation. During an interview, on 1/12/23 at 4:00 p.m., the Clinical Support Nurse indicated they did not have a policy for environment. The facility uses the resident rights policy. A current policy, titled "Resident Rights," dated as reviewed on 12/2/21 and received from the ED on 1/4/23 at 1:00 p.m., indicated "...Prior to or upon admission the designated staff member, will inform the resident and/or the resident's representative of the resident's rights and responsibilities. Resident rights. Safe environment...The resident has a right to a safe, clean, comfortable and Homelike environment, including but not limited to receiving treatment and supports for daily living...." This Federal tag relates to Complaint IN00388615. 3.1-19(f)(5)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit included the Investigation of Nursing Home Complaints	R 0000	The submission of this plan of correction does not indicate an admission by St. Elizabeth Healthcare Campus that the	

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	IN00381691, IN00381685, IN00381305, IN00390095 and IN00388615. Complaint IN00381691 - Substantiated. Federal/State deficiencies related to the allegations are cited at F565, F677, F690 and F725. Complaint IN00381305 - Substantiated. Federal/State deficiencies related to the allegations are cited at F565, F725 and F842. Complaint IN00390095 - Substantiated. Federal/State deficiencies related to the allegations are cited at F565, F725 and F812. Complaint IN00381685 - Substantiated. Federal/State deficiencies related to the allegations are cited at F565, F677, F690 and F725. Complaint IN00388615 - Substantiated. Federal/State deficiencies related to the allegations are cited at F921. Survey dates: January 4, 5, 6, 9, 10, 11 and 12, 2023 Facility number: 000187 Residential Census: 25 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on January 23, 2023.		findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the resident of St. Elizabeth Healthcare Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility herby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. The facility respectfully requests from the department a desk review for substantial compliance.	
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			

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	155290	A. BUILDING 00 B. WING	01/12/2023

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	services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (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 interview and record review, the facility failed to ensure service plans were signed and dated by the resident or resident's representative for 6 of 7 residents reviewed for service plans. (Resident 401, 403, 407, 405, 406, and 404) Findings include: 1. The record for Resident 401 was reviewed on 1/10/23 at 2:12 p.m. Diagnoses included, but were not limited to, hypothyroidism, anxiety disorder, and depressive disorder.	R 0217	Residents 401, 403, 407, 405, 406, and 404 were affected with no negative outcomes. Service plans updated with Residents and/or Representatives signatures and dates for the affected residents. All residents had the potential to be affected by this alleged deficient practice. An audit of all residents' service plans to ensure they are up to date, signed, and	02/06/2023

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	A service plan, dated as recorded on 2/25/2021, was not signed and dated by the resident or resident's representative. 2. The record for Resident 403 was reviewed on 1/10/23 at 11:06 a.m. Diagnoses included, but were not limited to, hyperlipidemia, diabetes, chronic kidney disease, and insomnia. A service plan, dated as recorded on 7/30/2022, was not signed and dated by the resident or resident's representative. 3. The record for Resident 407 was reviewed on 1/10/23 at 1:53 p.m. Diagnoses included, but were not limited to, hypertension, weakness, and acute respiratory failure. A service plan, dated as completed on 4/5/2022, was not signed and dated by the resident or resident's representative. 4. The record for Resident 405 was reviewed on 1/10/23 at 3:04 p.m. Diagnoses included, but were not limited to, diabetes, chronic pain, and nonalcoholic steatohepatitis. A service plan, dated as completed on 3/14/2022, was not signed and dated by the resident or resident's representative. 5. The record for Resident 406 was reviewed on 1/10/23 at 12:16 p.m. Diagnoses included, but were not limited to, cellulitis or right lower leg, urinary incontinence, neuropathy, and weakness. A service plan, dated as recorded on 7/27/2022, was not signed and dated by the resident or resident's representative.		dated. Staff will be re-inserviced on the policy "AL-Evaluation and Service Plan Guidelines" by ED of designee. The Executive Director or designee will audit 5 resident's services plans monthly to ensure they are being signed and dated by the resident and/or representative. The Executive Director or designee will report findings to QAPI for 6 months or until 100% compliance is maintained.	

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	6. The record for Resident 404 was reviewed on 1/10/23 at 11:28 a.m. Diagnoses included, but were not limited to, anxiety, hypertension, tremor, and osteoarthritis. A service plan was not signed and dated by the resident or resident's representative. During an interview, on 1/11/23 at 10:45 a.m., the Clinical Support Nurse indicated service plans should be signed by the resident or the resident's representative. A current facility policy, titled "AL-Evaluation and Service Plan Guidelines," dated as reviewed on 3/24/22 and received by the Clinical Support Nurse on 1/11/23 at 2:06 p.m., indicated "...A service plan shall be identified and implemented in response to the resident's evaluation and in collaboration with the resident and/or responsible party...."			