STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155769	A. BUILDING 00 B. WING	09/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORRISON WOODS HEALTH CAMPUS	4100 N MORRISON RD MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Nursing Home Complaints IN00386325 and IN00377976. This visit included the Investigation of Residential Complaint IN00384695. Complaint IN00386325 - Unsubstantiated due to lack of evidence. Complaint IN00377976 - Unsubstantiated due to lack of evidence. Complaint IN00384695 - Unsubstantiated due to lack of evidence. Survey dates: September 6, 7, 8, 9, 12, & 13, 2022 Facility number: 011596 Provider number: 155769 AIM number: 200901690 Census Bed Type: SNF/NF: 23 SNF: 27 Residential: 53 Total: 103 Census Payor Type: Medicare: 15 Medicaid: 19 Other: 16 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 16, 2022	F 0000	**Morrison Woods Health Campus POC Annual September 2022** Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during Recertification visit with exit on September 2022 . Please accept this Plan of Correction as the provider's credible allegation of compliance as of September 29, 2022 . The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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F 0645 SS=D Bldg. 00	483.20(k)(1)-(3) PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not			

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	provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.			
	Based on interview and record review, the facility failed to ensure a resident had a PASRR/Preadmission Screening completed upon admission for 1 of 1 residents reviewed for preadmission screening. (Resident 41) Findings include:	F 0645	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 41 identified as not having a PASRR Screening completed. PASRR screening has	09/29/2022

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	Resident 41's clinical record was reviewed on 9/8/22 at 10:07 a.m. Current diagnosis included, but were not limited to, anxiety, major depression, dementia, and unspecified psychosis. The resident was admitted to the facility on 8/1/22. The record lacked a PASRR/Preadmission screening. The resident had a 8/1/22 hospital discharge record which indicated: the resident had physician's orders for the antidepressant medications escitalopram/Lexapro and mirtazipine/Remeron. During an interview on 9/12/22 at 11:23 a.m., the Social Services Director indicated Resident 41 had not had a Preadmission screening/PASRR completed in error. The first screening was not completed due to an error with the social security number. She had intended to resubmit the information, but had forgotten to do so in error. She indicated she had resubmitted the screening on this date 9/12/22. A current, undated, facility policy, titled, "PASRR Quick Sheet," provided by the Corporate Nurse Consultant on 9/12/22 at 3:07 p.m., included, but was not limited to, the following: "New Admissions: If any of the following triggers a positive response, the Level 1 (MAP 409) will be checked YES...Individual has a severe mental illness/behavioral health (BH) diagnosis. ...Major Depression Disorder, Anxiety Disorder..." 3.1-16(d)		since been completed. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents with major mental health diagnoses have the potential to be affected by this. 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Director of Social Services educated on PASRR screening requirements. All referrals will be assessed for a need of a PASRR on admission and will be completed timely per regulations. Any residents with new orders for antipsychotics will have a PASRR completed and ensure they have an appropriate dx for the medication(s). 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; As a quality measure, The Executive Director or designee will review findings and any corrective actions for at least 6 months or until 100% compliance is maintained in the campus QAA meetings. This plan will be reviewed and updated as	

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			warranted.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview and record review, the facility failed to promptly revise the comprehensive care plan to reflect changes as they occurred for 1 of 2 residents reviewed for dialysis. (Resident 1)	F 0657	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 1 dialysis care plan was identified as lacking current	09/29/2022

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	Findings include: During an interview on 9/6/22 at 2:08 p.m., Resident 1 indicated she had dialysis at the dialysis center in the mornings on Tuesday, Thursday, and Saturday each week. During an observation on 9/8/22 at 11:18 a.m., the resident self propelled down the 200 unit hallway in her wheelchair from her room. She indicated she had not been to dialysis on this date. Resident 1's clinical record was reviewed on 9/8/22 at 3:24 p.m. Diagnoses included, but were not limited to the following: end stage renal disease, dependence on renal dialysis, and unspecified diastolic heart failure. Current physician orders included, but were not limited to the following: hemodialysis on Tuesday, Thursday, and Saturday. Complete Dialysis Center Communication Observation under 'Other Clinical Observation' and send with resident. A care plan for renal failure, dated 9/16/20, indicated the resident required dialysis. Interventions included, but were not limited to, coordinate care with dialysis center. The care plan lacked interventions for resident refusal of dialysis treatments. A Nurse's Note, dated 7/23/22, indicated the resident refused dialysis on this date. A Nurse's Note, dated 8/6/22, indicated the resident refused dialysis on this date. A Nurse's Note, dated 8/18/22, indicated the resident refused dialysis on this date.		interventions. Care plan has since been updated 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this. All residents care plans have been reviewed and updated as appropriate. 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All clinical leadership educated on Comprehensive Care Plans. As a measure of ongoing compliance, MDSC or designee to audit 5 resident care plans for completion and accuracy 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; As a quality measure, The Executive Director or designee will review findings and any corrective actions for at least 6 months or until 100% compliance is maintained in the campus QAA meetings. This plan will be	

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	A Nurse's Note, dated 9/8/22, indicated the resident refused dialysis on this date. The clinical record lacked documentation of dialysis center notification on the following dates the resident refused dialysis: 7/23/22, 8/6/22 and 8/18/22. During an interview on 9/12/22 at 3:44 p.m., the Corporate Nurse Consultant indicated the dialysis center should have been notified if the resident refused to go to dialysis. During an interview on 9/13/22 at 10:58 a.m., Licensed Practical Nurse (LPN) 5 indicated Resident 1 has been known to refuse dialysis and refused dialysis one day last week. The transportation service, dialysis center, and physician required notification when a resident refused dialysis. The communication should have been documented in the Nurse's Notes. During an observation at the time of interview on 9/13/22 at 11:13 a.m., the Corporate Nurse Consultant reviewed the residents care plan obtained from the clinical record on 9/8/22 and indicated it lacked any care plan interventions regarding dialysis refusals and notifications. Further information was not provided. A current policy, titled, "Comprehensive Care Plan Guideline," provided by the Corporate Nurse Consultant on 9/13/22 at 11:25 a.m., included, but was not limited to, the following: "PURPOSE...To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines. PROCEDURES...3. The comprehensive care plan should be... revised to		reviewed and updated as warranted.	

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	reflect changes in the resident's condition as they occur....6. Comprehensive care plans need to remain accurate and current...." 3.1-35(b)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure a resident who had an order for a hand splint had the hand splint applied as ordered for 1 of 1 resident reviewed for splint application as ordered by a physician. (Resident 17) Findings include: During an interview on 9/08/22 at 12:58 p.m., Resident 17's spouse indicated the resident had a hand splint that had somehow gone to the laundry and not returned. She indicated the brace had been missing about three weeks. She also indicated she had told a laundry worker and a therapy person about the missing splint, and it still had not been located. Resident 17's clinical record was reviewed on 9/07/22 at 9:38 a.m. Current diagnoses included, but were not limited to, contracture of muscle of the right hand, Parkinson's disease,	F 0684	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 17 remains in the facility and experienced no adverse effects related to alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents with splints ordered have the potential to be affected by this. Residents with splints have splints placed per physician order. 3 What measures will be put into	09/29/2022

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	hypothyroidism, and diabetes mellitus. The resident had a current, 6/03/2022, physician's order for a right hand splint to be checked and removed briefly for a skin integrity check and/or cleaning or shower one time each shift (three times a day). The resident had a current, 3/04/2022, care plan for the resident care profile which listed the services needed by the resident. Approaches to this need included, but was not limited to, "Ted Hose/Splints: right hand splint, trough arm on R [right] side W/C [wheelchair]." The clinical record for August 2022 and September 1 to 8, 2022 lacked documentation of the resident refusing to wear his hand splint. In addition, the clinical record lacked a care plan regarding the resident refusing to wear a splint prior to 9/8/22. The behavior monitoring record for, "Target Behavior-refusing hand brace" for 9/8/22 (date of initiation) to Sunday 9/11/22 lacked documentation of the resident refusing to wear his hand brace for 12 of 12 monitored shifts. During observations on the following dates and times the resident was observed without a hand splint in place: a. During an observation on 9/06/22 at 10:03 a.m., the resident was in his room, seated in a wheelchair. His feet were on the foot rest. He was well groomed in daytime clothing. He was not wearing a hand splint. b. During an observation on 9/06/22 at 10:35 a.m., the resident was in his wheelchair in the lounge during an activity. He was not wearing a hand splint.		place or what systemic changes will be made to ensure that the deficient practice does not recur; All clinical staff educated on applying splints as ordered. As a measure of ongoing compliance, DHS or designee will review all residents with splints to ensure they are in place as ordered 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; As a quality measure, The Executive Director or designee will review findings and any corrective actions for at least 6 months or until 100% compliance is maintained in the campus QAA meetings. This plan will be reviewed and updated as warranted.	

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	c. During an observation on 9/06/22 at 1:38 p.m., the resident was awake in bed. He indicated he was trying to take a nap. He was not wearing a hand splint. d. During an observation on 9/07/22 at 9:44 a.m., the resident was seated in a wheelchair in his room. He was dressed for the day. He was not wearing a hand splint. e. During an observation on 9/08/22 at 10:24 a.m., the resident was in the lounge in his wheelchair attending an activity. He was not wearing a hand splint. f. During an observation on 9/08/22 at 12:06 p.m., the resident was seated at a table in the dining room. He was not wearing a hand splint. g. During an observation on 9/08/22 at 12:57 p.m., the resident was in a wheelchair in his room without a hand splint. During an interview on 9/8/22 at 3:27 p.m., the Director of Nursing (DON) indicated Resident 17's hand splint had been found either yesterday or today (9/7/22 or 9/8/22). She indicated she believed the resident had a history of refusing to wear his brace. She had entered the specific behavior of refusing to wear a hand splint on the behavior tracking record to be monitored effective 9/8/22. During an interview on 3:43 p.m., the Corporate Nurse Consultant indicated the facility did not have a policy specific to the application of splints. 3.1-37			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services,			

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	consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview and record review, the facility failed to ensure communication between the dialysis center and the facility was documented in the clinical record for safe continuity of care for 2 of 2 residents reviewed for dialysis. (Residents 1 and 47) Findings include: 1. During an interview on 9/6/22 at 2:08 p.m., Resident 1 indicated she had dialysis at the dialysis center in the mornings on Tuesday, Thursday, and Saturday each week. During an observation on 9/8/22 at 11:18 a.m., the resident self propelled down the 200 unit hallway in her wheelchair from her room. She indicated she had not been to dialysis on this date. Resident 1's clinical record was reviewed on 9/8/22 at 3:24 p.m. Diagnoses included, but were not limited to the following: end stage renal disease, dependence on renal dialysis, and unspecified diastolic heart failure. Current physician orders included, but were not limited to the following: hemodialysis on Tuesday, Thursday, and Saturday. Complete Dialysis Center Communication Observation under 'Other Clinical Observation' and send with resident. Obtain vital signs and update dialysis observation upon return from dialysis on Tuesday, Thursday, and Saturday. A care plan for renal failure, dated 9/16/20,	F 0698	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 1 and Resident 47 remain in the facility and experienced no adverse effects related to alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents receiving dialysis have the potential to be affected. All clinical staff educated on Guidelines for Dialysis policy. 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; As a measure of ongoing compliance, DHS or designee to review all dialysis residents dialysis communication records for completion 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4 How the corrective action(s) will be	09/29/2022

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	indicated the resident required dialysis. Interventions included, but were not limited to, coordinate care with dialysis center, and observe catheter site per orders. The care plan lacked interventions for dialysis refusal. During a review of the resident's Dialysis Center Communication Form in observations, the following was observed: a. Communication form, dated 8/23/22, completed on 8/30/22, indicated the resident's hemodialysis treatment date was 8/23/22. Fluid Restrictions, Nutrition and Medications were blank. The area for Communication From Dialysis Center to Campus was not completed. b. Communication form, dated 8/25/22, completed on 8/31/22, indicated the resident's hemodialysis treatment date was 8/25/22. Transfer Time, Fluid Restrictions, Nutrition, and Medications were blank. The area for Communication From Dialysis Center to Campus was not completed. c. Communication form, dated 8/30/22, completed on 9/6/22, indicated the resident's hemodialysis treatment date was 8/30/22. Transfer Time, Mental Status, Nutrition, and Medications were blank. The area for Communication From Dialysis Center to Campus was not completed. Assessment upon return from dialysis was not completed. d. Communication form, dated 9/1/22, completed on 9/1/22, indicated the resident's hemodialysis treatment date was 9/1/22. Transfer Time, Mental Status, Condition of Shunt, Fluid Restrictions, Nutrition, Condition Change, and Medications were blank. The area for Communication From Dialysis Center to Campus was not completed.		monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; As a quality measure, The Executive Director or designee will review findings and any corrective actions for at least 6 months or until 100% compliance is maintained in the campus QAA meetings. This plan will be reviewed and updated as warranted.	

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	155769	A. BUILDING 00 B. WING	09/13/2022

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	e. Communication form, dated 9/3/22, completed 9/8/22, indicated the resident's hemodialysis treatment date was 9/3/22. Condition of Shunt, Fluid Restrictions, Nutrition, Condition Change, and Medications were blank. The area for Communication From Dialysis Center to Campus was not completed. Other notes indicated "Dialysis center did not fill out communication form." f. Communication form, dated 9/6/22, completed 9/6/22, indicated the resident's hemodialysis treatment date was 9/6/22. Transfer Time, Nutrition and Medications were blank. The area for Communication from Dialysis Center to Campus was not completed. Assessment upon return from dialysis was not completed. The clinical record lacked any Nurse's notes regarding dialysis communication for the following dates: 8/23/22, 8/25/22, 8/30/22, 9/1/22, 9/3/22, and 9/6/22. A review of the scanned documents lacked dialysis communication for the following dates: 8/23/22, 8/25/22, 8/30/22, 9/1/22, 9/3/22 and 9/6/22. A Nurse's Note, dated 7/23/22, indicated the resident refused dialysis on this date. A Nurse's Note, dated 8/6/22, indicated the resident refused dialysis on this date. A Nurse's Note, dated 8/18/22, indicated the resident refused dialysis on this date. A Nurse's Note, dated 9/8/22, indicated the resident refused dialysis on this date. The clinical record lacked documentation of			

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	dialysis center notification on the following dates the resident refused dialysis: 7/23/22, 8/6/22 and 8/18/22. During an interview on 9/9/22 at 1:59 p.m., Registered Nurse (RN) 4 indicated the top section of the Hemodialysis Communication Form was required to be completed and sent with the resident to the dialysis center. She indicated if the area did not apply it should have been marked not applicable and then signed rather than left blank. When the communication section of the form was not completed by the dialysis center upon resident return to the facility, the nurse was required to call the dialysis center and obtain the communication. The communication obtained was then documented in the dialysis communication observations with indication of who provided the communication from the dialysis center. The nurse was required to obtain the resident's vitals and an assessment upon return to the facility. It was not appropriate communication between the facility and the dialysis center if this information was not communicated. She was unaware of any other location in which the dialysis communication would be located. During an interview on 9/9/22 at 2:07 p.m., the Director of Nursing (DON) indicated the dialysis communication may also be found in a Progress Note or the dialysis scanned documents. During an interview on 9/9/22 at 2:20 p.m., the Corporate Nurse Consultant indicated the written or verbal communication between the facility and the dialysis center when the resident went to dialysis and upon return to the facility was required to be a part of the resident's clinical record. Documentation of an assessment was			

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	also required along with a full set of vitals and the assessment of the shunt or fistula. During a mock survey on 8/18/22 and 8/19/22 the facility recognized the communication from the dialysis center was missing. She indicated the facility initiated a plan of correction for the missing dialysis communication on 8/22/22. During an interview on 9/9//22 at 2:46 p.m., the DON indicated she obtained dialysis records from the dialysis center but they were not a part of the clinical record on 9/8/22. During an interview on 9/12/22 at 3:44 p.m., the Corporate Nurse Consultant indicated the dialysis center should have been notified if a resident refused to go to dialysis. During an interview on 9/13/22 at 10:58 a.m., Licensed Practical Nurse (LPN) 5 indicated Resident 1 has been known to refuse dialysis and refused dialysis one day last week. The transportation service, dialysis center, and physician required notification when a resident refused dialysis. The communication should have been documented in the Nurse's Notes. During an observation at the time of interview on 9/13/22 at 11:13 a.m., the Corporate Nurse Consultant reviewed the residents care plan obtained from the clinical record on 9/8/22 and indicated it lacked any care plan interventions regarding dialysis refusals and notifications. During an observation at the time of interview on 9/13/22 at 11:31 a.m., the Corporate Nurse Consultant reviewed the dialysis communication documentation and indicated it lacked required documentation and remained a problem.2. The clinical record for Resident 47 was reviewed on			

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	9/6/22 at 2:08 p.m. Diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis. A care plan, dated 8/11/22, for renal failure resulting in need for dialysis, included, but was not limited to, an intervention to coordinate care with the dialysis center. A current physician's order, dated 8/10/22, included, but was not limited to, dialysis on Monday, Wednesday, and Friday. Complete Dialysis Center Communication Observation under 'Other Clinical Observation' and send with resident. During a review of the resident's Dialysis Center Communication Forms, the following was observed: a. Communication form, dated 8/24/22, completed on 8/24/22, indicated "Renal dialysis" as the description of type of dialysis access and location (type of vascular access for dialysis treatment). Areas for Precautions, Nutrition and Fluid Restrictions were blank. The area for Communication From Dialysis Center to Campus was not completed. b. Communication form, dated 9/2/22, completed 9/3/22, indicated "Renal dialysis" as the description of type of dialysis access and location. Area for Precautions and Nutrition was blank. The area for Communication From Dialysis Center to Campus was not completed. c. Communication form, dated 9/7/22, no completion date, indicated "Renal dialysis" as the description of type of dialysis access and location. Area for Precautions and Nutrition was			

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	blank. The area for Communication From Dialysis Center to Campus was not completed. The Assessment Upon Return From Dialysis section was not completed. The form lacked vital signs. During an interview on 9/8/22 at 10:35 a.m., LPN 3 indicated the staff print the Dialysis Observation form and send it with the resident. The dialysis facility completed their portion and this was scanned into electronic health record. She has no other documentation regarding dialysis visits, but what was in the electronic health record. During an interview on 9/8/22 at 10:47 a.m., the Director of Nursing (DON) indicated that the dialysis provider usually had not sent any communication back with resident. If information was received, staff would enter this information into the Dialysis Observation. During an interview on 9/9/22 at 2:51 p.m., the DON indicated that the facility had performed a mock survey on 8/19/22 and found the facility had not completed consistent communication with the dialysis provider. She had not mentioned this in her previous interview and indicated "I don't know why." A current facility policy, revised 5/11/16, titled, "Guidelines for Dialysis," provided by the Corporate Nursing Consultant on 9/9/22 at 11:06 a.m., included, but was not limited to, the following: "Purpose: To provide communication to Dialysis Providers and monitoring of residents receiving dialysis... Procedure: 4. A report (may be written or verbal) shall be requested from the Dialysis Provider that			

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	will alert the campus regarding: a. Tolerance to procedure, b. vitals signs, c. medications administered d. other information deemed necessary for the ongoing provision of care. ...5. Upon return from the Dialysis Provider the campus shall:... b. Review the Dialysis Provider paperwork for any necessary follow up treatments." 3.1-37(a)			
F 0867 SS=D Bldg. 00	483.75(g)(2)(ii) QAPI/QAA Improvement Activities §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; Based on interview and record review, the facility failed to ensure systematic issues related to facility communication with a dialysis provider, as identified by the facility, were implemented according to a quality assessment and assurance plan for residents receiving dialysis services. (Residents 1 and 47) Findings include: During an interview on 9/9/22 at 2:51 p.m., the Director of Nursing (DON) indicated the facility had performed a mock survey on 8/19/22, and found the facility had not completed consistent communication documentation with the dialysis provider for the facilities two dialysis residents, Resident 1 and 47. The process was being implemented through the Quality Assurance and	F 0867	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Failure to implement QAPI corrective action plan. Residents 1 and 47 remain in the campus and no negative outcomes were experienced due to alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by alleged deficient	09/29/2022

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	Performance Program. She provided a completed "Episodic Event/Past Non-Compliance" form, dated 8/19/22, and completed on 8/22/22. The form included, but was not limited to, the following: "Event: Campus did not consistently receive report from dialysis center after dialysis completed on residents (1 and 47].....Auditing/Compliance: As a measure of ongoing compliance, DHS (Director of Health Services) or designee to monitor residents receiving dialysis for dialysis center communication 3 x (three times) a week for 4 weeks, then weekly x 2 (times two) months or until 100% compliance is maintained." An August 2022 audit document included, but was not limited to, initialed audit for the following dates: a. For Resident 47, an audit was completed and initialed by the DON on 9/7/22. The audit failed to identify the lack of dialysis communication documentation. No corrective actions were indicated on the audit form. Review of the communication form, dated 9/7/22, with no completion date, indicated "Renal dialysis" as the description of type of dialysis access and location (type of vascular access for dialysis treatments). Area for Precautions and Nutrition was blank. The area for Communication From Dialysis Center to Campus was not completed. The Assessment Upon Return From Dialysis section was not completed. The form lacked vital signs. b. For Resident 1, an audit was completed and initialed by the DON on 8/25/22. The audit failed to identify the lack of dialysis communication documentation. No corrective actions were		practice. All leadership educated on QAPI. 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; As a measure of ongoing compliance, ED or designee to review QAPI action plans for completion and accuracy weekly x 3 months then monthly x 3 months or until 100% compliance is maintained 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; As a quality measure, The Executive Director or designee will review findings and any corrective actions for at least 6 months or until 100% compliance is maintained in the campus QAA meetings. This plan will be reviewed and updated as warranted.	

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	indicated on the audit form. Review of the communication form, dated 8/25/22, lacked a transfer time, indication of a fluid restriction, type of nutrition and medications. The area for Communication From Dialysis Center to Campus was not completed. Review of a current facility policy, titled "Quality Assessment and Assurance Committee/Quality Assurance and Performance Improvement (QAPI) Program," revised 1/17/18, and provided by the Administrator following the Entrance Conference on 9/6/22, included, but was not limited to, the following: "QAPI Program Analysis and Action: 1. The facility shall review the delivery of clinical services, policies, and take actions as indicated aimed a performance improvement.....2. ...The plans shall be executed, communicated with appropriate staff, monitored, and reassessed for effectiveness with changes's made as appropriate until the compliance has been met." Cross reference F698. 3.1-52(b)(2)			
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 Residential Complaint IN00384695.This visit included the Investigation of Nursing Home Complaints IN00386325 and IN00377976.	R 0000	**Morrison Woods Health Campus POC Annual September 2022** Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on	

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	Complaint IN00384695 - Unsubstantiated due to lack of evidence. Complaint IN00386325 - Unsubstantiated due to lack of evidence. Complaint IN00377976 - Unsubstantiated due to lack of evidence. Survey dates: September 6, 7, 8, 9, 12, & 13, 2022 Facility number: 011596 Residential Census: 53 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 16, 2022		the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during Recertification visit with exit on September 2022 . Please accept this Plan of Correction as the provider's credible allegation of compliance as of September 29, 2022 . The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in 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 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.			

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	(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure assessments were performed to complete a service plan in a timely manner for 1 of 8 residents reviewed for service plans. (Resident 17) Findings include: The clinical record for Resident 17 was reviewed on 9/12/22 at 2:05 p.m. Diagnoses included, but were not limited to, Alzheimer's disease and unsteadiness on his feet. The resident admitted to the facility on 4/12/22. An admission Service Plan was completed on 9/8/22. During an interview on 9/13/22 at 2:13 p.m., the Corporate Nurse Consultant indicated the resident's service plan was not completed upon admission per facility policy. A current facility policy, reviewed 3/24/22, titled, "AL-Evaluation and Service Plan Guidelines," provided by the Corporate Nurse Consultant on 9/12/22 at 12:35 p.m., included, but was not limited	R 0217	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 17 remains in the campus. Service plan has since been completed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by alleged deficient practice. Clinical staff educated on AL Service Plan Guidelines. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; As a measure of ongoing compliance, DHS or designee to review service plans for completion and timeliness on all new admissions and 5 residents weekly x 3 months, then monthly x 3 months or until 100%	09/29/2022

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	to, the following: "Purpose To provide documentation of nursing and ancillary care needs to develop a service plan. To determine acuity level based on the amount of assistance provide with both activities of daily living (ADL) and nursing care. Procedure 1. Upon admission, semi-annually and with significant change in health status or functioning, the licensed nurse shall evaluate the resident's physical, mental, psychosocial functioning and care needs."		compliance is maintained. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; As a quality measure, The Executive Director or designee will review findings and any corrective actions for at least 6 months or until 100% compliance is maintained in the campus QAA meetings. This plan will be reviewed and updated as warranted.	
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on record review and interview, the facility staff failed to document the administration of ordered medications for 1 of 3 residents interviewed regarding medication administration. (Resident 27) Findings include: The clinical record for Resident 27 was reviewed on 9/13/22 at 9:50 a.m. Diagnoses included, but were not limited to, dementia, chronic kidney disease, hypertension and depressive episodes.	R 0243	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 27 remains in the campus. Resident did not experience any adverse effects related to alleged deficient practice. 2 How other residents having the potential to be affected by the	09/29/2022

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	Current signed physician's orders, included, but were not limited to, and a review of the resident's electronic medication administration record (eMAR) indicated the following:: a. Acetaminophen (to treat pain) 325 mg (milligram), two tablets (650 mg) every six hours for pain. The order was dated 8/6/22. On 9/7/22 at 12:00 a.m., the record indicated the mediation was not administered, with a comment of "due on previous nurse." b. Carbidopa-levodopa-entacaponne (to treat Parkinson's disease) 25-100-200 mg, one tablet every four hours. The order was dated 8/6/22. On 9/4/22 at 8:00 p.m., the record indicated the medication was not administered with a comment of "previous nurse." On 9/7/22 at 12:00 a.m., the record indicated the medication was not administered with a comment of "due on previous nurse." On 9/7/22 at 4:00 a.m., the record indicated the medication was not administered with a comment of "due on previous nurse." During an interview on 9/13/22 at 9:36 a.m., LPN 6 indicated the comment "due on previous nurse," indicated the previous shift nurse did not enter the administration on the eMAR. She indicated the nurse reported to her that she had given the medications during shift change. She had added the entries on 9/7/22 for the previous nurse. A current facility policy, revised 1/2017, titled, "Specific Medication Administration Procedures," provided by the Corporate Nurse Consultant on 9/13/22 at 2:23 p.m., included, but was not limited to, the following: "Policy To administer medications in a safe and effective		same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by alleged deficient practice. Clinical staff educated on medication administration guidelines. 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; As a measure of ongoing compliance, DHS or designee to review medication administration record for compliance on 5 residents 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; As a quality measure, The Executive Director or designee will review findings and any corrective actions for at least 6 months or until 100% compliance is maintained in the campus QAA meetings. This plan will be reviewed and updated as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155769	A. BUILDING 00 B. WING	09/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	manner. Procedures:...I. After administration, return to cart, replace medication container (if multi-dose and doses remain), and document administration in the MAR or TAR...."			
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on interview and record review, the facility failed to ensure narcotic count records and shift-to-shift information was complete and accurate for 2 of 2 medication records reviewed. (Halls 400 and 500) Findings include: A review of the Narcotic Count Sheet for the 400 and 500 Halls, provided by the Corporate Nurse Consultant 9/13/22 at 9:50 a.m., lacked the following information: 400 Hall On-coming nursing staff signature and Off-going nursing signature: for 1st shift on 9/9/22; for 2nd shift on 9/4/22 and 9/9/22; and for 3rd shift on 9/3/22, 9/6/22, 9/9/22, 9/10/22, 9/11/22, and 9/12/22. The count sheet lacked indication of number of narcotic medication counts for 24 of 27 shifts. 500 Hall On-coming nursing staff signature: for 1st shift on 9/2/22 and 9/11/22, for 2nd shift on 9/12/22; and for 3rd shift on 9/2/22, 9/3/22, 9/5/22, 9/7/22, 9/11/22, and 9/12.22.	R 0296	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by alleged deficient practice. Clinical staff educated on Guidelines for Narcotic count. 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; As a measure of ongoing compliance, DHS or designee to review narcotic count sheets on all medication carts for completion 3	09/29/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155769	A. BUILDING 00 B. WING	09/13/2022

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	500 Hall Off-going nursing signature: for 1st shift on 9/2/22, 9/7/22, and 9/11/22; for 2nd shift on 9/12/22; and for 3rd shift on 9/2/22, 9/3/22, 9/5/22, 9/7/22, 9/11/22, and 9/12/22. The count sheet lacked indication of number of narcotic medication counts for 23 of 27 shifts. During an interview on 9/13/22 at 9:39 a.m., the Corporate Nurse Consultant indicated the Narcotic Count Sheets were not complete. A current facility policy, revised 8/2/16, titled, "Guidelines for Narcotic Count," provided by the Corporate Nurse Consultant on 9/13/22 at 10:00 a.m., included, but was not limited to, the following: "Purpose To provide guidelines for tracking narcotic distribution. Procedures...2. The narcotic book shall contain a sheet providing space for the off going and oncoming nursing staff to record their signature indicating the narcotics has been reviewed. 3. The narcotic count sheet will indicate how many items are in the narcotic drawer and counted to ensure they are all present and accounted for. The count will be updated by two nurses to validate the changes with initials and date, as other items are added or removed. 4. At the time one nurse or other staff qualified to pass medications relinquishes the keys to the medication cart to another staff member the narcotics shall be reconciled by comparing the medications in the cart to the count sheets. 5. Both staff members shall sign the the narcotic count is accurately reconciled."		times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months or until 100% compliance is maintained. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; As a quality measure, The Executive Director or designee will review findings and any corrective actions for at least 6 months or until 100% compliance is maintained in the campus QAA meetings. This plan will be reviewed and updated as warranted.	