STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 00 B. WING	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaints IN00446534, IN00446557, IN00448532, IN00448749, and IN00450264. This visit included a State Residential Licensure Survey. Complaint IN00446534 - No deficiencies related to the allegations are cited. Complaint IN00446557 - No deficiencies related to the allegations are cited. Complaint IN00448532 - No deficiencies related to the allegations are cited. Complaint IN00448749 - Federal/State deficiencies related to the allegations are cited at F677, F689, F842, and F9999. Complaint IN00450264 - No deficiencies related to the allegations are cited. Survey dates: January 16, 17, 21, 22, 23, 24, and 27, 2025 Facility number: 000439 Provider number: 155716 AIM number: 100275070 Census Bed Type: SNF/NF: 118 SNF: 9 Residential: 11 Total: 138 Census Payor Type: Medicare: 4	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance citedduring the Recertification and State Licensure with Complaint survey conducted January 27, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 26, 2025. 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
Tara Trevino	Executive Director	02/20/2025

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

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	Medicaid: 93 Other: 30 Total: 127 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 7, 2025.			
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice Based on interview and record review, the facility failed to ensure SNF-ABN (Skilled Nursing Facility-Advanced Beneficiary Notice) Forms were provided following the end of Medicare skilled services for 1 of 2 residents who discharged from Medicare services and remained in the facility. (Resident Z) Finding includes: On 1/17/25 at 9:45 A.M., the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review Forms were reviewed. The form indicated Resident Z received Medicare Part A Skilled Services starting 12/4/24. The form indicated the last covered day of Part A services was 1/14/25 and the resident remained in the facility. The form indicated Resident Z did not receive a SNF-ABN (Skilled Nursing Facility-Advanced Beneficiary Notice) Form because she was scheduled to be discharged home on 1/15/25 following the last covered day, but family failed to pick up the resident who remained in the facility. At that time, the Administrator indicated a SNF-ABN had not been issued to the resident. During an interview on 1/21/25 at 12:41 P.M., the	F 0582	**F 582** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident Z was discharged from the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Residents being cut from Medicare Part A and remaining in the facility have the potential to be affected. A SNF ABN will be issued to any residents who are being cut from Medicare Part A and remaining in the facility. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** IDT was educated on the process	02/26/2025

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	Administrator indicated Resident Z was still in the facility and would be responsible for the fees associated with room and board for her stay in the facility between 1/14/25 and whenever she was discharged. On 1/23/25 at 9:30 A.M., Resident Z's clinical record was reviewed. The census indicated Resident Z was admitted on 12/4/24 with Medicare as the payer source. On 1/15/25 the payer source was changed to private pay. On 1/22/25 the resident was discharged from the facility. On 1/27/25 at 12:31 P.M., the Administrator provided a Notice of Medicare Non-Coverage (NOMNC) policy, revised 10/1/23, that did not address the SNF-ABN form requirements. During an interview on 1/27/25 at 2:47 P.M., the Administrator indicated that the facility did not have a policy that addressed SNF-ABN forms and expected the facility to follow federal regulations for form requirements and distribution. 3.1-4(f)(2)		for issuing a SNF ABN. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit will be completed by BOM or designee weekly for all residents discharged from Medicare Part A who are remaining in the facility to ensure that the SNF ABN was issued. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements Based on interview and record review, the facility failed to ensure a resident's discharge was documented in the clinical record for 1 of 3 residents reviewed for discharge. (Resident 60) Finding includes: On 1/23/25 at 12:24 P.M., Resident 60's clinical	F 0622	**F 622** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident 60 has been discharged from the facility. Unable correct	02/26/2025

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	record was reviewed. Resident 60 was admitted on 2/24/22. Diagnoses included, but were not limited to, Parkinson's Disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/5/24, indicated Resident 60 was moderately cognitively impaired, required substantial assistance from staff (staff does more than half of the work) for toileting and transfers, and was dependent on staff for bathing. A nutrition note created on 1/17/25 at 2:09 P.M., indicated Resident 60 was discharged with return not anticipated. The clinical record, including progress notes, assessments, and documents, lacked information regarding planning of a discharge, documents sent during discharge, where Resident 60 was discharged to, or when discharge occurred. During an interview on 1/23/25 at 2:58 P.M., the Admissions Director indicated Resident 60 left the facility on 1/16/25 after a planned discharge and went to another long term care facility, but was unable to find any documentation of discharge planning. On 1/23/25 at 2:35 P.M., the Administrator provided a document titled Summary of Episode Note, created on 1/17/25, and indicated nursing staff should make a progress note when a resident leaves the facility stating when they left, where they went, and what was sent with the resident. On 1/27/25 at 12:31 P.M., the Administrator provided a policy titled Discharge Summary and Plan, dated 8/2024, that indicated "When a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed to		past missed documentation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any resident discharged from the facility has the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** IDT educated on the need to complete documentation for discharge planning. Nursing staff educated on the need to document discharges in the clinical record. Discharges will be reviewed in clinical meetings five times per week to ensure that the proper documentation of discharge planning is completed. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit will be completed by DNS or designee on all discharges weekly to determine if the proper documentation was completed. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or	

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	assist the resident with discharge. Every resident is evaluated for his or her discharge needs and has an individualized post-discharge plan. A member of the interdisciplinary team reviews the final post-discharge plan with the resident and family at least 24 hours before discharge takes place. A copy of the following is provided to the resident and receiving facility and a copy will be filed in the resident's medical records: an evaluation of the resident's discharge needs, the post-discharge plan, and the discharge summary." 3.1-12(a)(6)(A) 3.1-12(a)(6)(B)		updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025.	
F 0645 SS=D Bldg. 00	483.20(k)(1)-(3) PASARR Screening for MD & ID Based on interview and record review, the facility failed to ensure social services were provided to meet a resident's mental and psychosocial needs for 1 of 1 residents reviewed for Preadmission Screening and Resident Review (PASARR). (Resident 61) Finding includes: On 1/22/25 at 2:14 P.M., Resident 61's clinical record was reviewed. Diagnoses included, but were not limited to, Wernicke's encephalopathy, alcohol use disorder, non-Alzheimer's dementia, seizures, anxiety, depression, and an unspecified psychiatric disorder. The resident was admitted to the facility on 1/20/24. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/20/24, indicated the resident was cognitively intact, required supervision for all mobility tasks, and received antipsychotics, antianxiety medication,	F 0645	**F 645** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** A new Level 1 PASRR has been completed for resident 61. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Residents with newly identified mental illness after the completion of initial PASRR will have an updated level 1 completed prior to admission. Current residents will be audited to determine if level 1 accurately reflects their current diagnosis and an updated PASRR	02/26/2025

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	antidepressants, and anticonvulsants during the 7-day look back period. Physician orders included, but were not limited to: olanzapine (an antipsychotic medication) oral tablet 10 milligrams (mg) - 1 tablet at bedtime, dated 11/21/23. Valium (an antianxiety medication) oral tablet 2 mg - 1 tablet by mouth twice daily, dated 6/3/24. Wellbutrin XL (an antidepressant) oral tablet Extended Release 24 Hour - give 150 mg by mouth one time a day, dated 1/21/24. thiamine (vitamin given to alcoholics to prevent Wernecke's encephalopathy) HCl oral tablet - give 100 mg by mouth one time a day, dated 1/21/24. Target behaviors: psychosis, delusions, hallucinations- to be monitored and charted on at the end of each shift, dated 10/13/24. Observe closely for significant side effects from antipsychotic medication use such as sedation, drowsiness, dry mouth, constipation, blurred vision, abnormal tremors/facial/tongue movements, weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention. Notify provider if observed and document in progress notes, dated 10/13/24. May utilize (name of mental health facility) for counseling services, dated 9/29/24. Target behaviors: depression- tearfulness, withdrawn, agitation, excessive crying, or social isolation. To be monitored and documented at the end of each shift, dated 8/9/24.		will be completed if needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** IDT will be educated on the PASRR process and regulations. Newly added diagnosis will be reviewed in the daily clinical meeting to determine if an updated PASRR may be required. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit will be completed by social services weekly on 10 residents for three months, then on 5 residents per week for three months to determine if an updated PASRR may be required. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	

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	Target behaviors: anxiety- self-reported nervousness, restlessness, sleeplessness, etc. To be monitored and documented at the end of each shift, dated 6/24/24. Resident may reside on secured memory care unit, dated 6/6/24. Antianxiety medication- monitor for drowsiness, slurred speech, dizziness, nausea, aggressive/impulse behavior. Monitor and document at the end of each shift, dated 6/4/24. Current care plans included, but were not limited to: Resident resides on secured memory care unit. She has a diagnoses of dementia, Wernicke's Encephalopathy, alcohol induced persisting amnestic disorder, and other signs involving cognitive function and awareness. She has a history of exit seeking and wanting to leave to go home. Date Initiated: 1/24/24 Resident is at risk for ineffective coping due to unexpected loss of loved one (sister and spouse). Date Initiated: 2/1/24. Interventions included: Psych services as needed. Date Initiated: 2/1/24. On 1/23/25 at 9:00 A.M., the Administrator provided a copy of a PASARR completed for Resident 61 in April 2023, 8 months prior to the resident's admission to the facility. During an interview on 1/27/25 at 9:52 A.M., the Administrator indicated that Resident 61's diagnoses were updated after the previous PASARR was completed and the Admissions Director should have reviewed the PASARR on admission to make sure it was current and updated.			

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	On 1/27/25 at 12:31 P.M., the Administrator provided an Admissions Criteria policy, dated 8/2024, that indicated "All new admissions and readmissions are screened for mental disorders (MD), intellectual disorders (ID), or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review process". 3.1-34(a)			
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan Based on interview and record review, the facility failed to ensure the development and completion of a baseline care plan within forty-eight (48) hours of admission for use of respiratory equipment, tracheostomy, and Enhanced Barrier Precautions (EBP) for 1 of 1 residents reviewed for respiratory care. (Resident 277) Finding includes: On 1/21/25 at 11:21 A.M., Resident 277's clinical record was reviewed. Resident 277 was admitted on 1/13/25. Diagnoses included, but were not limited to, chronic respiratory failure with hypoxia and tracheostomy. The Admission Minimum Data Set (MDS) Assessment was in progress. Current physician orders included, but were not limited to, the following: Change oxygen tubing monthly and as needed (PRN), one time a day every four weeks on Sunday for Oxygen (O2) use and as needed for soiled or compromised, dated 1/15/25.	F 0655	**F 655** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Unable to complete the missed 48-hour baseline care plan in the past. Resident 277 has a person-centered comprehensive care plan in place. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** New admissions have the potential to be affected by a missed 48-hour baseline care plan. New admissions will have a baseline care plan completed. **What measures will be put into place and what systemic changes will be made to**	02/26/2025

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	Change humidifier/bubbler monthly and as needed (PRN), as needed for empty/compromised and change one time a day every four weeks on Sunday for routine oxygen, dated 1/15/25. Resident requires the use of Enhanced Barrier Precautions (EBP) related to the medical device (Tracheostomy & Peg Tube) to reduce the risk of transmission of Multiple Drug-Resistant Organisms (MDROs) every shift for Isolation Precautions. Use Personal Protective Equipment (PPE) precautions when providing prolonged direct resident care, dated 1/14/25. The clinical record lacked a base line care plan for the tracheostomy, oxygen use, and EBP protocol. During an interview on 1/23/25 at 11:35 A.M., the Assistant Director of Nursing (ADON) indicated that a baseline care plan was based on the initial assessment that the admitting nurse completed. The initial assessment included, but was not limited to, physical assessment of the resident and oxygen use with a baseline care plan initiated within 48 hours of admission. On 1/27/25 at 12:31 P.M., the Administrator provided a current Care Plans, Baseline policy, revised 8/2024, that indicated "A baseline care plan to meet the resident's immediate health and safety needs is developed within forty-eight (48) hours of admission. The baseline care plan includes instructions to provide effective, person-center care for the resident to meet professional standards of practice and must include the minimum healthcare information to properly care for the resident...". 3.1-30(a)		**ensure that the deficient practice does not recur:** Nursing and IDT educated on the requirements for the completion of a baseline care plan. All new admissions will be reviewed five times per week in the daily clinical meeting to determine if the baseline care plan has been completed and ensure completion. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit will be completed by DNS or designee weekly on all new admissions to determine if the baseline care plan has been completed. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	

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F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on record review and interview, the facility failed to ensure care plans were updated after a fall for 1 of 6 residents reviewed for falls. (Resident 8) Finding includes: On 1/21/25 at 3:19 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, chronic pain syndrome, spinal stenosis lumbosacral region, and age-related physical disability. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 12/13/24, indicated the resident was mildly cognitively impaired, required substantial to maximal help (staff does more than half) with dressing, required partial to moderate assistance of staff (staff does less than half) with transferring, and had one fall with injury since the prior assessment. Current physician orders included, but were not limited to: 1/4 side rails for mobility positioning every day and night shift to aide with bed mobility related to morbid (severe) obesity, dated 11/20/20. A current falls care plan, dated 12/12/17, indicated that Resident 8 was at risk for falls related to potential side effects of medications (cardiac, opioid, psychological etc.). Interventions included, but were not limited to, the following: Medication review, labs, and orthostatic blood pressures, initiated on 1/20/25. Pain management, initiated 12/2/24. There should be a safe environment with even	F 0657	**F 657** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Falls care plan for resident 8 has been reviewed and is current. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Residents with falls have the potential to be affected. Residents with a fall in the past 30 days will have falls care plans reviewed and updated if indicated. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing and IDT were educated on the requirement to update the care plan interventions and document following each fall. All falls will be reviewed in clinical meetings five times per week to ensure that documentation is in place and interventions are updated on the care plan. **How the corrective action will be monitored to ensure the**	02/26/2025

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	floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Side rails as ordered, handrails on walls, personal items within reach initiated on 12/17/17 and revised on 8/2/23. An Interdisciplinary Team (IDT) note, dated 12/2/24 at 9:50 A.M., indicated that Resident 8 had an unwitnessed fall with injury on 11/27/24 at 9:45 P.M. The intervention for that fall was to provide an environmental assessment. The clinical record lacked documentation to indicate the new intervention was added to the plan of care. During an interview on 1/23/25 at 3:15 P.M., the Administrator indicated there should be a new intervention after each fall and the care plan was not updated with a new intervention after the resident fell on 11/27/24. On 1/27/25 at 12:31 P.M., the Administrator provided a current Comprehensive Care plans policy, revised 8/2024, that indicated "comprehensive assessments are utilized in developing person-centered care plans...a significant change is a major decline or improvement in a resident's status that will not normally resolve itself without intervention by staff...". 3.1-35(d)(2)		**deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit will be completed by DNS or designee on all falls weekly to ensure that documentation is in place and interventions are added to the care plans. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards Based on observation, record review, and interview, the facility failed to ensure physician orders were followed for 2 of 5 residents reviewed	F 0658	**F 658** **What corrective action will be accomplished for those**	02/26/2025

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	for nutrition. (Resident 35 and Resident L) Findings include: 1. During an observation on 1/21/25 at 10:15 A.M., Resident 35's lower extremities were swollen. Resident 35 indicated she was supposed to wear compression stockings to reduce edema but staff had not put them on for her. On 1/21/25 at 1:37 P.M., Resident 35's clinical record was reviewed. Resident 35 was admitted on 10/8/24. Diagnoses included, but were not limited to, renal failure and diabetes mellitus. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/16/25, indicated Resident 35 was cognitively intact and required substantial assistance from staff (staff does more than half of the work) for toileting, bathing, and transfers. Current physician orders included, but were not limited to: Patient to wear stockings on bilateral lower extremities (Tubigrips size G) for edema reduction and management. Nursing to assist patient in donning compression stockings in the AM (morning), doffing at HS (bedtime); Start date 11/21/24. 2. On 1/21/25 at 12:34 P.M., Resident L's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most recent Annual Minimum Data Set (MDS) Assessment, dated 12/23/24, indicated Resident L was moderately cognitively impaired and required substantial assistance from staff (staff does more than half of the work) for		**residents found to have been affected by the deficient practice:** Resident 35 has Tubigrip orders placed on the TAR and on Tasks for the CNAs. Tubigrips have been applied per order. Resident L has been weighed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Other residents with orders for Tubigrip have the potential to be affected. All orders for Tubigrip have been placed on the TAR and on Tasks for the CNAs. Residents are wearing Tubigrip per orders. Residents with orders for weights have the potential to be affected. All residents' orders for weights have been verified for correct frequency, and all weights have been obtained per orders or refusals documented. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing staff educated on the necessity to follow doctor's orders and document the completion of or refusal of orders. Nursing educated on the importance of obtaining accurate weights when	

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	toileting, bathing, and mobility. Physician orders included, but were not limited to: Obtain weight one time only for monitoring for three days; Start date: 1/14/25 The clinical record, including progress notes, vitals, and medication and treatment administration records, lacked documentation of a weight recorded since 1/1/25. During an interview on 1/24/25 at 1:25 P.M., the Director of Nursing (DON) indicated the weights ordered on 1/14/25 were not obtained and left blank in the order administration record. During an interview on 1/27/25 at 12:31 P.M., the Administrator indicated the facility did not have a written policy for following physician orders, but it was the facility's policy to follow the physician orders as written. 3.1-35(g)(1)		ordered. IDT will review all new orders five times per week in the clinical meeting to ensure they are placed appropriately on the TAR or Task if needed and to determine if any new orders for weights were received. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit will be completed by DNS or designee on 10 residents per week to monitor for the completion of weights or the documentation of refusals. An audit will be completed by DNS or designee on five residents with orders for Tubigrip per week to determine if they were applied per order, or if refused, that documentation was completed. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	

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F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review, and interview, the facility failed to ensure assistance at meals or assistance with bathing was provided for 7 of 8 residents reviewed for Activities of Daily Living (ADL) tasks. (Resident L, Resident S, Resident G, Resident U, Resident R, Resident N, and Resident T) Findings include: 1. During a continuous observation on 1/16/25 beginning at 12:08 P.M., a kitchen staff member was observed delivering trays to the dining room. Staff removed trays from the cart and placed them at the dining tables. Resident L was observed sitting in a recliner facing the dining area. Staff served all the residents at the dining tables, then collected trays as residents were done eating. At 12:41 P.M., Resident L called out to staff for help out of the recliner. At 12:47 P.M., staff transferred Resident L out of the recliner into a wheelchair and wheeled him to the dining table where Resident L ate alone. On 1/21/25 at 12:34 P.M., Resident L's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most recent Annual Minimum Data Set (MDS) Assessment, dated 12/23/24, indicated Resident L was moderately cognitively impaired and required substantial assistance from staff (staff does more than half of the work) for toileting, bathing, and mobility. Meal intake for Resident L was not documented for lunch or dinner on 1/16/24.	F 0677	**F677** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Assistance with meals was provided for resident L and meal consumption was documented. Residents S, G, U, R, and N were given showers. Resident T is no longer in the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Residents requiring assistance with dining or showers have the potential to be affected. Residents have been assisted with dining and meal consumption was documented, and residents have received showers. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing staff were educated on the importance of providing showers per preference or documenting refusals of care. Nursing staff were educated on the importance of assisting with dining and documenting meal consumption.	02/26/2025

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	2. During an interview on 1/21/25 at 10:54 A.M., Resident S indicated showers were not being given according to the plan of care. On 1/22/25 at 9:15 A.M., Resident S's clinical record was reviewed. Diagnoses included, but were not limited to, chronic ulcers and congestive heart failure. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/9/25, indicated Resident S required substantial assistance (staff does more than half of the work) from staff for bathing. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated that bathing/showers were to be given on Monday and Thursday dayshift, before breakfast, Offer full or partial bed bath on non-shower days. Resident S's clinical record lacked showers provided on the following preferred days in December 2024 and January 2025: 12/2/24 12/12/24 1/13/25 1/20/25 On 12/19/24 at 12:03 P.M. and 1/9/25 at 5:51 P.M., shower refusals were documented but did not follow resident preference of time of day offered. 3. On 1/22/25 at 1:55 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most recent Quarterly Minimum Data Set		IDT audited shower tasks in POC to ensure that shower tasks match resident preferences. IDT will review POC charting five days a week in clinical meeting for documentation of showers and meal consumption. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DNS or Designee will monitor meal service attendance five meals per week for 4 weeks, then three meals per week for 4 weeks, then one weekly for 16 weeks to ensure that residents requiring assistance are served at the same time as the other residents in the area. DNS or Designee will audit 10 residents per week for the completion of showers as assigned and completion of documentation. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:**	

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	(MDS) Assessment, dated 12/24/24, indicated Resident G was severely cognitively impaired and required substantial assistance (staff does more than half of the work) for bathing and transferring. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering task indicated that Bathing (prefers showers) schedule: Tuesday and Friday night shift. Resident G's clinical record lacked showers provided on the following preferred days in December 2024 and January 2025: 1/3/25 1/10/25 1/17/25 1/21/25 4. On 1/21/25 at 2:04 P.M., Resident U indicated she did not receive showers twice a week. On 1/22/25 at 2:03 P.M., Resident U's clinical record was reviewed. Diagnoses included, but were not limited to, atrial fibrillation. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 12/27/24, indicated Resident U was cognitively intact, required supervision of staff for bathing, and had no rejection of care during the 7-day look back period. A preferences care plan, dated 6/20/23, indicated the resident preferred showers every other day at night time. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated Resident U received showers on Wednesdays and Saturdays on night shift. Resident U did not receive or refuse a shower on		February 26, 2025	

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	the following days in December 2024 and January 2025: 12/4/24 12/7/24 12/14/24 12/25/24 1/11/25 5. On 1/21/25 at 2:04 P.M., Resident R indicated he did not receive showers twice a week. On 1/22/25 at 2:10 P.M., Resident R's clinical record was reviewed. Diagnoses included, but were not limited to, pulmonary fibrosis. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 1/11/25, indicated Resident R was cognitively intact, required substantial to maximal assistance of staff (staff does more than half) for bathing, and had no rejection of care during the 7-day look back period. A choices care plan, revised 1/4/24, indicated the resident preferred showers on Tuesdays and Fridays during the day. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated Resident R received showers on Tuesdays and Fridays before bed. Resident R did not receive or refuse a shower on the following days in December 2024 and January 2025: 12/6/24 12/13/24 12/17/24 12/20/24 12/27/24 12/31/24 1/3/25			

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	1/7/25 1/10/25 1/14/25 1/17/25 6. On 1/21/25 at 2:04 P.M., Resident N indicated she did not receive showers twice a week. On 1/22/25 at 2:18 P.M., Resident N's clinical record was reviewed. Diagnoses included, but were not limited to, chronic pain syndrome. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 12/19/24, indicated Resident N was cognitively intact, required substantial to maximal assistance of staff (staff does more than half) for bathing, and had no rejection of care during the 7-day look back period. An Activities of Daily Living (ADL) care plan, dated 8/6/23, indicated the resident required physical assistance of one with bathing due to chronic pain. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated Resident N received showers on Mondays and Fridays on day shift. Resident N did not receive or refuse a shower on the following days in December 2024 and January 2025: 12/6/24 12/13/24 12/20/24 12/23/24 1/6/25 7. In an anonymous interview, it was indicated that Resident T had not been getting his showers and smelled like he hadn't showered and was			

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	"living on the streets". Staff had indicated they didn't brush Resident T's teeth because he was care planned to brush his own teeth even though Resident T was right-arm dominant and that arm had been broken and was in a sling. On 1/21/25 at 1:39 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease with late onset, fracture of distal end of femur, fracture of fibula, and tibial plateau fracture (right side). The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 7/29/24, indicated Resident T had mild to moderate cognitive impairment, exhibited behaviors that included other behaviors not directed towards anyone that had worsened since the previous assessment, and required substantial to maximal assistance (staff does more than half) with oral hygiene and showering. A current Activities of Daily Living (ALD) care plan, dated 2/25/22, included the following interventions: The resident requires extensive assist by one staff with bathing/showering. The resident can be independent but occasionally does require extensive assist by one staff for personal hygiene and oral care. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated Resident T received showers on Tuesdays and Fridays. Resident T did not receive or refuse a shower on the following days in June and July 2024: 6/11/24 7/12/24 7/19/24			

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	A nursing progress note, dated 7/24/24 at 6:45 P.M., indicated the Registered Nurse (RN) noted Resident T to have poor oral hygiene, could not change his clothing on his own, and that he was in need of someone to help in doing hygiene such as brushing teeth, bathing, and changing clothes. On 1/22/25 at 2:39 P.M., the Director of Nursing (DON) indicated that all showers were charted in POC Tasks. Shower sheets were used but were not part of the clinical record. During an interview with the Administrator on 1/27/25 at 12:31 P.M., she indicated there was no written policy related to the timing of showers, but residents were expected to receive showers twice weekly. On 1/27/25 at 12:31 P.M., the Administrator provided a policy titled Assistance with Meals, dated 8/2024, that indicated "Facility staff will serve resident trays and will help residents who require assistance with eating. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity". This citation relates to Complaint IN00448749. 3.1-38(a)(2)(A) 3.1-38(a)(2)(D) 3.1-38(a)(3) 3.1-38(b)(1) 3.1-38(b)(2)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on interview, observation, and record	F 0686	**F686** **What corrective action will be**	02/26/2025

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	review, the facility failed to promote the prevention of pressure ulcer development through evaluation of clinical risk factors and implementation of interventions consistent with resident needs for 1 of 2 residents reviewed for facility acquired pressure injuries. (Resident G) Finding includes: During an anonymous interview, it was indicated Resident G had a decline in mobility since admission and was being left in the same position for long periods of time resulting in skin breakdown. During an observation on 1/23/25 at 8:57 A.M., Resident G was sitting in a recliner in the common area. The chair did not have a pressure reducing cushion for skin breakdown prevention. On 1/22/25 at 1:55 P.M., Resident G's clinical record was reviewed. Resident G was admitted on 12/9/24. Diagnoses included, but were not limited to, dementia. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/24/24, indicated Resident G was severely cognitively impaired, required substantial assistance (staff do more than half of the work) for bathing and transferring, and was at risk for pressure ulcers. Current physician orders included, but were not limited to: Pressure reducing cushion to chair/wheelchair every shift, Start date 12/9/24. The care plan included, but was not limited to: I am at risk for impaired skin integrity related to bowel and bladder incontinence, Date Initiated:		**accomplished for those residents found to have been affected by the deficient practice:** Pressure injury risk factors identified, and interventions implemented, and care planned for Resident G. Meeting held with family and physician to review current resident status and orders. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Other residents at risk of pressure injury have the potential to be affected. Branden assessment completed for residents to identify those at high risk for pressure injury. Interventions reviewed, implemented, and/or care planned as needed for residents at high risk. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing educated on the importance of identifying risk factors for pressure injury and ensuring implementation of interventions as ordered. CNAs have been educated regarding ensuring the accuracy of documentation in their POC.	

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	12/10/24. The care plan did not include an individualized repositioning schedule. A progress note, dated 1/23/25 at 6:08 A.M., indicated Resident G had an open area on his coccyx. The clinical record lacked notification to family or physician of open wound. A progress note, dated 1/23/25 at 4:29 P.M., indicated Resident G had open areas on bilateral buttocks. The wound nurse was notified. A skin/wound note dated 1/23/25 at 4:39 P.M., indicated Resident G had five open wounds on his bilateral buttocks, including two stage two wounds (partial thickness skin loss). The following dates and times were documented as no skin issues in the skin observation task: 1/21/25 12:57 P.M. 1/22/25 7:42 P.M. 1/23/25 6:16 P.M. 1/24/25 8:40 A.M. On 1/27/25 at 12:31 P.M., the Administrator provided a policy titled Prevention of Pressure Injuries, dated 8/2024, that indicated " Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. Evaluate, report, and document potential changes in the skin." 3.1-40(a)(1) 3.1-40(a)(3)		Nurse managers will audit pressure relieving device orders to ensure that they are on tasks, orders, and care plan. IDT will review any new skin issues or orders in clinical meetings five times a week to ensure that appropriate interventions are ordered, implemented, and care planned. Family and physician notifications will be reviewed during the clinical meetings to ensure proper notifications have been completed. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit will be conducted on 10 residents per week to ensure that interventions are ordered, implemented, documented and care planned. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview and record review, the facility failed to ensure post fall assessments were completed, care plans were updated, and interventions were in place to prevent falls for 3 of 6 residents reviewed for falls. (Resident W, Resident P, and Resident G) Findings include: 1. On 1/22/25 at 8:59 A.M., Resident W's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease. The most current Annual Minimum Data Set (MDS) Assessment, dated 12/3/24, indicated Resident W had moderate cognitive impairment, required substantial to maximal assistance of staff (staff does more than half) for bed mobility, toileting, and bathing, and had no falls since the prior assessment on 9/3/24. A current fall risk assessment, dated 1/5/25, indicated Resident W was at high risk for falls. A current falls care plan, revised 9/12/22, indicated Resident W had a potential for falls related to impaired balance. A current Activities of Daily Living (ADL) care plan, revised 9/7/22, indicated Resident W required assistance of two staff for bed mobility, transfers, toileting, and bathing. Physician orders included, but were not limited to: Nursing must chart using hot charting progress note for every shift. Monitor vital signs every shift post fall for 72 hours to rule out any	F 0689	**F 689** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Unable to complete post fall assessments in the past. Care plans updated and interventions in place to prevent falls for residents W, P, and G. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Residents with falls have the potential to be affected. Residents with a fall in the past 30 days will have falls care plans reviewed and updated if indicated. Unable to complete post fall assessments in the past. Interventions are in place for these residents. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing and IDT were educated on the requirement to update the assessments, care plan interventions and to complete documentation following each fall. IDT was educated that a follow up	02/26/2025

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	155716	A. BUILDING 00 B. WING	01/27/2025

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	abnormal results or fluctuations every shift for three days, dated 1/7/25 A change in condition note, dated 1/5/25 at 6:48 P.M., indicated Resident W had a fall due to altered mental status and was sent to the Emergency Room (ER) for evaluation and treatment. A health status note, dated 1/6/25 at 2:18 P.M., indicated Resident W returned from the hospital with a diagnosis of Urinary Tract Infection (UTI). Imaging done at the hospital was normal. An Interdisciplinary Team (IDT) note, dated 1/7/25 at 10:09 A.M., indicated Resident W's fall was reviewed and a new intervention to monitor vital signs over 72 hours for any fluctuations or abnormal results post fall was added to the care plan. A Nurse Practitioner (NP) note, dated 1/8/25 at 11:59 P.M., indicated the resident was seen due to "increased pain and altered mental status following a recent fall and hospitalization, where she was diagnosed with a UTI and received various diagnostic tests. Her vital signs show erratic blood pressure and an elevated pulse, raising concerns for potential sepsis ... Continue close monitoring of vital signs, particularly blood pressure and heart rate". An alert note, dated 1/13/25 at 4:04 P.M., indicated after continued complaints of pain, the Nurse Practitioner (NP) ordered a repeat x-ray that showed an acute fracture of the distal femur, and the resident was sent to the ER for evaluation and treatment. Hospital discharge papers, dated 1/13/25 at 5:55		note is required when the intervention involves monitoring for a specific amount of time, or if a resident returns from an outside provider with new interventions. All falls will be reviewed in clinical meetings five times per week to ensure that assessments are completed, documentation is in place and interventions are updated on the care plan. If a monitoring intervention is used, the IDT will complete a follow-up during the scheduled clinical meeting following the completion of monitoring. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit will be completed by DNS or designee on all falls weekly to ensure that any post fall assessments are completed, documentation is in place and interventions are added to the care plans, and any IDT follow-up documentation is completed. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved.	

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	P.M., indicated the resident was being discharged with a primary diagnosis of fracture of distal end of femur, fracture of fibula, and tibial plateau fracture (right side). A nursing progress note, dated 1/13/25 at 7:22 P.M., indicated the resident returned to the facility with an immobilizer in place on her right leg. The clinical record lacked documentation that the intervention "monitor vital signs x 72 hours" was reviewed for effectiveness or that the care plan was updated after the resident returned from the hospital on 1/13/25 with a new diagnosis of femur fracture and an immobilizer in place. In an interview on 1/22/25 at 9:56 A.M., the Director of Nursing (DON) indicated that the terminology "hot charting" was to remind the nurse they had something specific to chart. Vital sign hot charting would be documented in the vital signs tab. On 1/23/25 at 9:45 A.M., the Regional Support provided a weights and vitals summary for Resident W from 1/7/24 to 1/9/24. The following vital signs were not charted once per shift during that time: Blood pressure - 1/8/25 night shift, 1/9/25 night shift Pulse - 1/8/25 night shift Temperature - 1/8/25 day shift and night shift Pain level - 1/7/25 night shift, 1/9/25 day shift and night shift Respiration - 1/8/25 day shift and night shift, 1/9/25 day shift and night shift Oxygen Saturation - 1/8/25 day shift and night shift, 1/9/25 day shift and night shift.2. On 1/22/25 at 1:55 P.M., Resident G's clinical record was reviewed. Resident G was admitted on 12/9/24.		**By what date the systemic changes for each deficiency will be completed:** February 26, 2025	

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	Diagnoses included, but were not limited to, dementia. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 12/24/24, indicated Resident G was severely cognitively impaired and required substantial assistance (staff do more than half the work) for bathing and transferring. A fall risk assessment, dated 1/15/25, indicated Resident G was a high risk for falls and had fallen multiple times in the past in the past three months. The care plan included, but was not limited to: I am at risk for falls/injury due to: impaired cognition related to dementia, history of falls, initiated 12/10/24, Interventions included: Assess for pain, Date Initiated: 12/13/24 call light is within reach, Date Initiated: 12/13/24 Ensure pathways are free of clutter, Date Initiated: 12/13/24 Keep personal items within reach, Date Initiated: 12/13/24 Physical therapy to eval (evaluate) and treat as indicated, Date Initiated: 1/9/25 Staff education regarding ambulation of resident to assist with restlessness, Date Initiated: 1/17/25 Nonskid mat at bedside, Date Initiated: 1/17/25 Fall 1: On 12/21/24 at 6:37 A.M., an incident note indicated Resident attempted to get out of the recliner without assistance and slid to bottom of the recliner with legs on floor. Resident G was encouraged to use call light when needing assistance to avoid unsafe transfers. On 12/23/24 at 9:03 A.M., an Interdisciplinary Team (IDT) note indicated the IDT team agreed that the intervention for the fall on 12/21/24 was to offer toileting prior to getting up.			

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	The care plan was not updated with the new fall intervention for fall one. Fall 2: On 1/9/25 at 9:21 A.M., an IDT note indicated IDT reviewed a witnessed fall that occurred on 1/8/25. Resident G was reaching for his walker and fell forward. An immediate intervention of 72 hour hot charting was implemented and a new order was entered for physical therapy to evaluate and treat. Fall 3: On 1/15/25 at 11:30 P.M., Resident G was found sitting on the floor near his bed scooting using his hands and feet. Resident G was attempting to self-transfer unassisted and had impaired memory and unsteady gait. The care plan was updated with nonskid mat at bedside. Fall 4: On 1/21/25 6:07 A.M., a nursing progress note indicated Resident G slid onto the floor. The resident experienced minor pain and was transferred back to the chair. The clinical record lacked a post-fall assessment, notification to the physician or family, an intervention following the fall, and an update to the plan of care for fall four. Fall 5: On 1/26/25 at 4:05 P.M., a nursing progress note indicated a nurse and Certified Nurse Aide (CNA) attempted to transfer Resident G. Resident G slid to the floor. The clinical record lacked a post-fall assessment, notification to the physician or family, an intervention following the fall, and an update to the plan of care for fall five. Fall 6: On 1/26/25 at 10:24 P.M., a nursing progress			

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	note indicated Resident G slid out of bed onto the floor. The clinical record lacked a post-fall assessment, notification to the physician or family, an intervention following the fall, and an update to the plan of care for fall six. During an interview on 1/23/25 at 11:39 A.M., the Therapy Manager indicated Resident G was not receiving therapy because insurance had not approved services, and was not receiving daily restorative therapy. During an interview on 1/27/25 at 2:50 P.M., the Administrator and Director of Nursing (DON) indicated they could not find fall assessments for Resident G on 1/21/25 and 1/26/25 and were unaware Resident G had fallen either dates. 3. On 1/22/25 at 2:47 P.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and a right intertrochanteric femur fracture. The most current Significant Change Minimum Data Set (MDS) Assessment, dated 11/11/24, indicated the resident was not cognitively intact, required substantial to maximum assistance (staff does more than half) with transfers, and had no falls since the prior assessment. The most current fall risk assessment, dated 12/25/24, indicated Resident P was at high risk for falls. A current risk for falls care plan, initiated 5/2/24, indicated the resident was at risk for injury from a fall due to impaired cognition and dementia. A Communication with the Family note, dated			

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	12/30/24 at 8:00 P.M., indicated the resident's family member was notified of a witnessed fall in the hallway with no injury. A Skilled Charting Note, dated 12/30/24 at 11:00 P.M., included vital signs and a skin/wound assessment. The note lacked documentation regarding the resident's witnessed fall. A Nurse Practitioner (NP) note, dated 12/30/24 at 11:59 P.M., indicated that the resident was seen per staff/resident request for a fall. An Interdisciplinary Team (IDT) note, dated 12/31/24 at 9:26 A.M., indicated the fall that occurred on 12/30/24 at 11:00 A.M. was reviewed. Resident P was witnessed attempting to stand from her wheelchair without the wheels locked and slid to floor. The care plan was updated with the new intervention to apply anti-rollbacks to the wheelchair. The clinical record lacked documentation to indicate Resident P was assessed immediately after falling on 12/30/24. During an interview on 1/27/25 at 9:52 A.M. the Administrator indicated an initial assessment was not charted after the fall that occurred at 11:00 A.M. until the skilled assessment at 11:00 P.M that night. During an interview on 1/23/25 at 11:15 A.M., the Administrator indicated care plans were revised with a new intervention after each fall. The clinical team would meet the next day after a fall, discuss what the most appropriate intervention would be, and look for an intervention that would prevent the next fall or a fall of the same nature. If the intervention was to monitor vital signs, obtain			

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	labs, or review medications, the clinical team would meet to follow up on that intervention to determine if it were the cause of the fall, in which case orders were requested from the physician. If it was determined it was not the cause of the fall, another new intervention would be decided upon and placed in the plan of care. On 1/23/25 at 12:15 P.M., the DON provided a current Assessing Falls and Their Causes policy, effective 8/2024, that indicated "When a resident falls, the following information should be recorded in the resident's medical record: The condition in which the resident was found... Assessment date, including vital signs and any obvious injuries ... Notification of the physician and family ... Appropriate interventions taken to prevent future falls ... Notify the following individuals when a resident falls: The resident's family; The Attending Physician ... Report other information in accordance with facility policy and professional standards of practice". On 1/27/25 at 12:31 P.M., the Administrator provided a current Falls and Fall Risk, Managing policy, effective 8/2024, that indicated "If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions ... If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling...". This citation relates to Complaint IN00448749. 3.1-45(a)(2)			
F 0695 SS=D	483.25(i) Respiratory/Tracheostomy Care and			

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Bldg. 00	Suctioning Based on observation, record review, and interview, the facility failed to ensure residents received respiratory care services in accordance with professional standards of practice for 1 of 1 residents reviewed for respiratory care. The facility failed to date oxygen tubing, oxygen concentrator, and suction tubing, and place signs that indicated oxygen was in use. (Resident 277) Finding includes: On 1/21/25 at 9:17 A.M., Resident 277's oxygen tubing, suction tubing, and oxygen concentrator were observed without a label and date. There were no oxygen signs observed that indicated the resident received oxygen. Resident was observed to have a tracheostomy. During the observation of Resident 277's tracheostomy care on 1/22/25 at 8:34 A.M., the obturator for emergency tracheostomy use was not identified in the room. On 1/22/25 at 8:53 A.M., Resident 277's oxygen tubing, suction tubing, and oxygen concentrator were observed without a label and date. There were no oxygen signs observed that indicated the resident received oxygen. On 1/21/25 at 11:21 A.M., Resident 277's clinical record was reviewed. Diagnoses included, but were not limited to, chronic respiratory failure with hypoxia and tracheostomy. The Admission Minimum Data Set (MDS) Assessment was in progress. Current physician orders included the following: Oxygen (O2) - six liters per tracheostomy mask.	F 0695	**F 695** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The oxygen tubing, oxygen concentrators, and suction tubing for Resident 277 have been dated. Signs have been placed notifying that oxygen is in use for Resident 277. An emergency obturator is in place in the resident's room. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Other residents with oxygen, tracheostomy or suctioning have the potential to be affected. All residents with oxygen tubing, oxygen concentrators or suction tubing have them in place and dated. Any resident with a tracheostomy has the obturator in place in the room for emergencies. All residents with oxygen have a sign in place indicating that oxygen is in use. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing staff have been educated on dating oxygen tubing,	02/26/2025

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	Titrate to keep O2 saturation greater than 92% at bedtime, dated 1/15/25. Change oxygen tubing monthly and as needed (PRN), one time a day every 4 weeks on Sunday for oxygen use and as needed for soiled or compromised, dated 1/15/25. Change humidifier/bubbler [sic] (container) monthly and PRN for empty/compromised, and change one time a day every 4 weeks on Sunday for routine oxygen, dated 1/15/25. The clinical record lacked a base line care plan for the tracheostomy and oxygen use. During an interview on 1/22/25 at 2:35 P.M., the Director of Nursing (DON) indicated the oxygen tubing, suction tubing, and concentrator should be labeled. There should be a sign on the outside of the door indicating oxygen use. On 1/22/25 at 9:56 A.M., the DON provided a current Oxygen Administration policy, revised 8/2024, that indicated "the purpose of this procedure was to provide safe guidelines for safe oxygen administration...equipment needed...no smoking/Oxygen in use sign on the outside of the room entrance door...". 3.1-47(a)(4) 3.1-47(a)(5) 3.1-47(a)(6)		concentrators, and suction tubing and the need to maintain signs indicating that oxygen is in use. Nurses have been educated on the need to maintain the obturator in a resident's room if they have a tracheostomy, for emergency tracheostomy insertion. IDT will review orders in clinical meeting five times per week and ensure that any residents with new respiratory care orders have all tubing dated and oxygen signage in place as required. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DNS or designee will audit all residents with tracheostomies each week to ensure that the obturator is in place for emergency insertion. DNS or designee will audit five residents with respiratory care orders each week for the presence of dates and labels on oxygen tubing, suction tubing, or concentrators and ensure that an "oxygen in use" sign is present. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of	

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			100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis Based on interview and record review, the facility failed to follow physician orders and provide ongoing assessment of the resident's condition and monitoring for complications by completing pre-dialysis evaluations assessments for 1 of 1 residents reviewed for dialysis management. (Resident 35) Finding includes: On 1/21/25 at 1:37 P.M., Resident 35's clinical record was reviewed. Resident 35 was admitted on 10/8/24. Diagnoses included, but were not limited to, renal failure and peripheral vascular disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/16/25, indicated Resident 35 was cognitively intact and required substantial assistance from staff (staff does more than half of the work) for toileting, bathing, and transfers. Current physician orders included, but were not limited to: Do not obtain blood pressure in the left arm, Start date 10/8/24. Pre-Dialysis assessment to be completed prior to dialysis one time a day every Monday, Wednesday, Friday for pre-dialysis assessment; Start date 10/9/24	F 0698	**F 698** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** A pre-dialysis assessment has been completed for Resident 35 with blood pressure taken in the Right arm. Care profile updated to reflect blood pressure in the right arm only. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Other residents with dialysis have the potential to be affected. All dialysis residents have had a pre-dialysis assessment completed following resident specific instructions. Care profiles have been updated for any restrictions regarding blood pressures in specific extremities. **What measures will be put into place and what systemic changes will be made to**	02/26/2025

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	Post-Dialysis assessment to be completed after each dialysis appointment one time a day every Monday, Wednesday, Friday for baseline post-dialysis assessment, Start date 10/9/2024 The following dates and times included blood pressures documented obtained from the left arm: 12/1/24 2:11 P.M. 12/4/24 2:54 P.M. 12/5/24 10:03 A.M. 12/11/24 9:34 A.M. 1/7/25 11:20 A.M. 1/8/25 7:56 A.M. 1/15/25 11:33 A.M. 1/15/25 5:47 P.M. 1/22/25 8:00 A.M. 1/22/25 3:22 P.M. A pre-dialysis assessment on 12/31/24 contained vitals including blood pressure, from a previous date (12/27/24). A pre-dialysis assessment on 1/10/25 contained vitals, including blood pressure, from a previous date (1/8/25). A pre-dialysis assessment on 1/24/25 contained vitals, including blood pressure, from a previous date (1/22/25). During an interview on 1/24/25 at 1:32 P.M., the Director of Nursing (DON) indicated Resident 35's blood pressure should not be taken in the left arm. During an interview on 1/27/25 at 12:31 P.M., the Administrator indicated the facility did not have a written policy for following physician orders, but it was the facility's policy to follow the physician orders as written.		**ensure that the deficient practice does not recur:** Nurses were educated on the need for pre and post-dialysis assessments as well as the need to follow any vital sign restrictions and to document results. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DNS or designee will monitor the completion of pre and post dialysis assessments for all dialysis residents, including obtaining and documenting vital signs, three times weekly for 8 weeks and then weekly for four months. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	

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	A policy related to assessment of dialysis patients was requested and not provided. 3.1-37(a)			
F 0712 SS=D Bldg. 00	483.30(c)(1)-(4) Physician Visits-Frequency/Timeliness/Alt NPP Based on interview and record review, the facility failed to ensure a resident was assessed by a physician since admission for 1 of 1 residents reviewed for dialysis. (Resident 35) Finding includes: During an interview on 1/23/25 at 3:00 P.M., Resident 35 indicated she had not been assessed by a physician in the facility since admission. On 1/21/25 at 1:37 P.M., Resident 35's clinical record was reviewed. Resident 35 was admitted on 10/8/24. Diagnoses included, but were not limited to, renal failure and peripheral vascular disease. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 1/16/25, indicated Resident 35 was cognitively intact and required substantial assistance from staff (staff does more than half of the work) for toileting, bathing, and transfers. The clinical record, including assessments, progress notes, and documents, lacked assessment of Resident 35 by a physician in the facility since admission. During an interview on 1/24/25 at 11:39 A.M., the Administrator indicated she was unable to find any physician assessments since admission for	F 0712	**F 712** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Physician has evaluated the Resident 35. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected. An audit was completed on all residents. Any resident who was due or past due for a physician evaluation has been completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** IDT was educated on the requirements for physician visits and the physician was provided with the results of the audit indicating who was due for an	02/26/2025

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	Resident 35. On 1/27/25 at 12:31 P.M., the Administrator provided a policy titled Choice of Attending Physician, dated 8/24, that indicated "The attending physician requirements and responsibilities include: participating in the resident assessments and care planning; Physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current OBRA regulations and facility policy." 3.1-22(d)(1)		evaluation. Physician will be provided with a list of new residents on scheduled weekly rounding days and a monthly list of residents who are due for ongoing evaluation. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** ED or designee will audit physician visits monthly for compliance. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview, and record review, the facility failed to ensure meals were served at a palatable temperature for 1 of 1 trays tested for temperature. (North Hall) Finding includes:	F 0804	**F 804** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Food has been served at a	02/26/2025

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	On 1/17/25 at 10:46 A.M., Resident 118 indicated the food tasted bad and was cold. On 1/21/25 at 10:13 A.M., Resident 35 indicated the food temperature was never what it was supposed to be. Her hot foods were not hot and her cold foods were not cold. On 1/21/25 at 10:53 A.M., Resident S indicated the food was cold when she got it and hot plates were sometimes not used to keep it warm while delivering it to residents. On 1/23/24 at 12:45 P.M. a test tray was obtained. Food temperatures from that meal were: Cheeseburger 100.6 F (Fahrenheit) Sweet potato fries 87 F The food tasted lukewarm and the cheeseburger was observed to be pink in the middle of the meat. On 1/23/24 at 12:50 P.M., the Dietary Supervisor indicated that the burgers used were precooked. On 1/27/25 at 12:31 P.M., the Administrator provided a Food Temperatures policy, dated 2021, that indicated "foods sent to the units for distribution (such as meals, snacks, nourishments, oral supplements) will be transported and delivered to unit storage areas to maintain temperatures at or below 41 degrees F for cold foods and at or above 135 degrees F for hot foods". 3.1-21(a)(2)		palatable temperature for all residents. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents who receive food from the kitchen have the potential to be affected. All residents have been served food at a palatable temperature. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Dietary staff have been educated on the need to ensure that food leaves the kitchen at appropriate temperatures and that the heated covers are used as appropriate. Nursing staff have been educated on the need to ensure that trays are passed in a timely manner to ensure food is served at the correct temperatures. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DNS or Designee will monitor meal service attendance during five meals per week for 4 weeks, then three meals per week for 4	

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			weeks, then one weekly for 16 weeks to ensure that residents requiring assistance are served at the same time as the other residents in the area and that food is served promptly to allow for proper temperatures. Dietary Manager or designee will audit food temps five meals per week for 4 weeks, then three meals per week for 4 weeks, then one weekly for 16 weeks to ensure that food is served at a palatable temperature. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on interview and record review, the facility failed to ensure documentation was complete and accurate for 1 of 3 residents reviewed for discharge from Medicare Part A and 1 of 6 residents reviewed for falls. (Resident Z and Resident T) Attempts to contact the family were not documented and details of an injury from a fall were not documented accurately.	F 0842	**F 842** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Residents T and Z are no longer in the facility.	02/26/2025

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	Findings include: 1. During an interview on 1/17/25 at 9:45 A.M., the Administrator indicated Resident Z was scheduled to be discharged home on 1/15/25, but family failed to pick up the resident. The facility had attempted to call the resident's family, but they had not answered the phone. During an interview on 1/17/25 at 9:58 A.M., Resident Z'a family member indicated that Resident Z was at the facility short term for rehab and was due to be discharged soon. They were waiting on a phone call from the Social Services Director (SSD) to set a date for discharge but had not yet heard anything. On 1/17/25 at 10:45 A.M., Resident Z's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure. The most current Admission Minimum Data Set (MDS) Assessment, dated 12/11/24, indicated Resident Z was cognitively intact and received physical and occupational therapy. Current care plans, dated 12/11/24, indicated the resident anticipated a short-term stay. Physician orders included, but were not limited to: Resident may discharge with Home Health of choice, dated 1/7/25 A late entry social services note, dated 1/13/25 at 8:54 A.M., indicated the resident was to discharge home on 1/15/24 and a family member would pick her up that day. A late entry social services note, dated 1/15/25 at		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any resident whose family is contacted has the potential to be affected. Attempts to contact families have been documented in the clinical record. Residents with falls have the potential to be affected. Documentation will be completed accurately for residents with falls. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Nursing and IDT have been notified of the necessity for accurate documentation and that any attempts to contact families must be documented in the clinical record. All clinical progress notes will be reviewed by the IDT in the clinical meeting five times per week for accuracy and need for further family notification. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit will be completed by	

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	8:58 A.M., indicated the SSD left a voicemail for the family member asking when the resident would be picked up. The clinical record lacked documentation to indicate the facility attempted to call the family member between 1/15/25 at 8:58 A.M. and 1/17/25 at 12:47 P.M. A Social Service note, dated 1/17/25 at 12:47 P.M., indicated the SSD spoke with the family member and arrangements were made for discharge from the facility on 1/22/25. During an interview on 1/24/25 at 3:20 P.M., the Administrator indicated the Social Services Director was no longer employed by the facility and documentation of attempts to contact Resident Z's family between 1/15/25 and 1/17/25 could not be found. 2. On 1/21/25 at 1:39 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, a Alzheimer's disease with late onset, nondisplaced fracture of greater tuberosity of right humerus, and other displaced fracture of upper end of right humerus. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 7/29/24, indicated the resident was not cognitively intact, required substantial to maximum assistance (staff does more than half) with toileting, showering/bathing, bed mobility, and transfers, and had two or more falls with major injury since the last assessment. An incident note, dated 7/19/24 at 10:44 A.M., indicated Resident T fell in his room. The resident complained of hip and neck pain. Resident T was assessed and "had no injury, with the exception		DNS or designee on all falls weekly to ensure that documentation is in place and family notification is completed and documented. An audit will be completed by DNS or designee on 10 residents per week to determine if there is any missing notification of family documentation. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	

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	of, his previous injury in his left upper and lower arm with bruises visible to almost all of left arm". The Social Service Director (SSD) "then decided to put a sling on resident provided by facility due to the sling the resident had currently, was not stable and did not elevate their left arm". A nursing progress note, dated 7/19/24 at 10:50 A.M., indicated Resident T had bruising and discoloration on his right arm from his neck to his wrist. During an interview on 1/27/25 at 9:52 A.M., the Administrator indicated she was unsure of which arm the resident hurt during the fall that occurred on 7/19/24 but it was most likely his right arm. At that time, she indicated it was not typical for the SSD to make the determination to put a sling on a resident, and the progress note was documented inaccurately. On 1/27/25 at 12:31 P.M., the Administrator provided a current Charting and Documentation policy, effective 8/2024, that indicated "The following information is to be documented in the resident medical record:...progress towards or changes in the care plan goals and objectives ... Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate". This citation relates to Complaint IN00448749. 3.1-50(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure the proper	F 0880	**F 880** **What corrective action will be**	02/26/2025

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	use of Enhanced Barrier Protocol (EBP), Personal Protective Equipment (PPE), and hand washing for 2 of 2 residents reviewed for wound care and 1 of 1 residents reviewed for tracheostomy care. (Resident 13, Resident 18, Resident 277) Findings include: 1. On 1/21/25 at 11:21 A.M., Resident 277's clinical record was reviewed. Diagnoses included, but were not limited to, chronic respiratory failure with hypoxia and tracheostomy. Physician orders included, but were not limited to: Resident requires the use of Enhanced Barrier Precautions (EBP) related to the medical device (Tracheostomy & Peg Tube) to reduce the risk of transmission of multidrug-resistant organisms (MDROs) every shift for Isolation Precautions. Use Personal Protective Equipment (PPE) precautions when providing prolonged direct resident care, dated 1/14/25. On 1/22/25 at 8:34 A.M., Resident 227 was observed with a tracheostomy. There was not an Enhanced Barrier Precaution (EBP) sign observed in the resident's room. On 1/22/25 at 8:58 A.M., Licensed Practical Nurse (LPN) 23 was observed performing tracheostomy care for Resident 227. LPN 23 did not wear a gown during care. LPN 23 did not wash her hands prior to putting on gloves and opening items for a sterile field. The items were placed onto the sterile field and LPN 23 removed her gloves. LPN 23 washed her hands for 15 seconds with soap and water prior to putting on sterile gloves. LPN 23 proceeded to place a sterile suction catheter into right hand while using left hand to remove speaking valve. LPN 23 then suctioned Resident		**accomplished for those residents found to have been affected by the deficient practice:** EBP sign has been placed for Resident 227. Dressing changes for residents 13, and 18 were completed using proper PPE, EBP, and handwashing. Tracheostomy care was provided for Resident 277 using proper PPE, EBP, and handwashing. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** An audit will be completed to determine which residents require EBP. Other residents requiring EBP have the potential to be affected. Residents in EBP were provided care with the proper use of PPE and handwashing. EBP signs are placed for each resident who is on EBP. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Staff will be educated on Enhanced Barrier Precautions, how to identify who requires them, and what those precautions entail. Staff will be educated on handwashing for wound and tracheostomy care as well as	

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	227 three times to clean out the tracheostomy tube. After the suctioning was complete, LPN 23 removed the old trach dressing, removed her gloves, and did not perform hand hygiene. LPN 23 donned new sterile gloves, kept her right hand sterile, and utilized her left hand to remove the inner cannula. LPN 23 removed the dirty gloves, but did not perform hand hygiene before donning another pair of sterile gloves to place the sterile new inner cannula into the tracheostomy. LPN 23 placed a clean dressing under the cannula. LPN 23 did not perform hand hygiene after completing the care. During an interview on 1/22/25 at 9:18 A.M., LPN 23 indicated Resident 277 should be on EBP due to the tracheostomy. During an interview on 1/22/25 at 9:36 A.M., the Infection Preventionist indicated gloves should be changed each time when going from dirty to clean tasks and hands should be washed in between glove changes. 2. On 1/23/25 at 2:30 P.M., Licensed Practical Nurse (LPN) 23 and LPN 3 were observed performing wound care for Resident 18. An EBP sign was present on the door indicating the precautions and the PPE necessary when providing direct care. LPN 23 and LPN 3 did not wear wear a gown while providing wound care to five areas on the resident's lower legs. On 1/24/25 at 3:00 P.M., Resident 18's clinical record was reviewed. Diagnoses included, but were not limited to, peripheral vascular disease, varicose veins with ulcer to left leg, and varicose veins with ulcer to right leg. The clinical record lacked orders and a care plan		proper use of PPE. IDT will review new orders and progress notes five times a week during clinical meetings to identify any residents requiring the initiation of EBP. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DNS or designee will perform an audit of 10 residents per week to determine if they should be in EBP, and if the proper signage and PPE are in place. DNS or designee will complete an observation audit of 5 staff performing care in EBP to monitor for the proper use of PPE and handwashing. These observations will occur with a variety of staff members on different days and shifts and will include at least one tracheostomy care and one wound care observation. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	

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	for Enhanced Barrier Precautions. 3. On 1/22/25 at 10:27 A.M., Resident 13's clinical record was reviewed. Diagnoses included, but were not limited to, stage three pressure ulcer. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 12/7/24, indicated Resident 13 had moderate cognitive impairment, was dependent on staff for all Activities of Daily Living (ADLs), and had two stage three pressure injuries. Physician orders included, but were not limited to: Resident requires the use of Enhanced Barrier Precautions related to chronic wound to reduce the risk of transmission of multidrug-resistant organisms (MDROs). Use personal protective equipment (PPE) precautions when providing prolonged direct resident care, dated 11/14/24. A stage three pressure ulcer to right posterior lateral calf care plan, dated 7/2/24, included an intervention for enhanced barrier precautions. A stage three pressure ulcer to left lateral lower leg care plan, dated 7/2/24, included an intervention for enhanced barrier precautions. A diabetic ulcer to left second toe care plan, dated 12/27/24, included an intervention for enhanced barrier precautions. On 1/23/25 at 10:41 A.M., Licensed Practical Nurse (LPN) 3 and LPN 19 were observed performing a dressing change for Resident 13's wounds. A sign indicating the resident was on Enhanced Barrier Precautions (EBP) was observed in the room. LPN 3 and LPN 19 did not wear a gown during the dressing change procedure.			

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	During an interview on 1/23/25 at 12:58 P.M., the Director of Nursing (DON) indicated staff should wear all the proper PPE, including gown and gloves, when contacting residents on EBP. There should be a sign on the door indicating EBP protocol. On 1/22/25 at 9:56 A.M., the DON provided a current Enhanced Barrier Precautions policy, revised 8/2024, that indicated "...EBP employs targeted gown and glove use during high contact resident care activities...Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include device care...tracheostomy...wound care (any skin opening requiring dressing) ... Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE provided...". On 1/27/25 at 12:31 P.M., the Administrator provided a current Handwashing and Hand Hygiene policy, revised 8/2024, that indicated "...the facility considers hand hygiene the primary means to prevent the spread of...infections ... Indications for hand hygiene include: ... before moving from work on a soiled body site to a clean body site on the same resident and immediately after glove removal...". 3.1-18(b)(2) 3.1-18(l)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment during 7 random observations. Odor was present in the facility and	F 0921	**F 921** **What corrective action will be accomplished for those residents found to have been**	02/26/2025

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	puddles of fluid and debris were on the floor. (West Hall, East Hall, 500-hall, Pavilion Dining Room) Findings include: 1. On 1/16/25 at 9:23 A.M., an unattended rolling cart of trash sitting in front of East Hall nurses station had an odor consistent with bowel movement. 2. On 1/16/25 at 9:32 A.M., the 500-hall had a strong putrid smell. 3. On 1/16/25 at 9:35 A.M., the West Hall was noted to have an odor consistent with bowel movement. 4. On 1/16/25 at 12:37 P.M., the Pavilion dining room floor had a large puddle of fluid and dirty debris observed along the dining room floors. 5. On 1/21/25 at 8:00 A.M., the East Hall was noted to have an odor consistent with urine. 6. On 1/23/25 at 8:10 A.M., the East Hall was noted to have an odor consistent with urine. 7. On 1/23/25 at 10:41 A.M., the West Hall was noted to have an odor consistent with bowel movement. During an interview on 1/24/25 at 9:19 A.M., the Housekeeping Supervisor indicated that managing odors was a part of the housekeeping staff's daily cleaning tasks. All housekeepers have odor eliminating supplies on their cart and odors were taken care of as soon as they were noticed. On 1/27/25 at 12:31 P.M., the Administrator provided a current Homelike Environment policy,		**affected by the deficient practice:** The unattended rolling trash cart has been emptied. The areas of the facility where there were odors have been cleaned. The floor in Pavilion dining room was swept and mopped. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Residents in all areas have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Staff have been educated that the barrels with trash and soiled linens may not be left unattended on the halls, spills of liquids or food need to be promptly cleaned, and that areas with odors should be addressed to ensure that residents are cleaned and soiled linens and trash are removed. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** ED or designee will round on at least two areas of the facility per	

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	effective 8/2024, that indicated "The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include...pleasant, neutral scents". 3.1-19(f)		day five times per week for six weeks, then three times per week for six weeks, then weekly for 12 weeks to identify if there are any unattended trash barrels, spills of food or liquids, or odors noted that are not being addressed by the staff on duty. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	
F 9999 Bldg. 00	State Finding #1. 3.1-13 ADMINISTRATION AND MANAGEMENT (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed	F 9999	**F9999** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** 1 Resident T is no longer in the facility. The incident was reported for Resident W. 2 QMA 1, LPN 3, Cook 5, RN 7, Dietary 22, RN 9, and CNA 11 have completed six hours of dementia specific training. **How other residents having the potential to be affected by the**	02/26/2025

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	by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (D) major accidents. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to report a fall with major injury to the Indiana Department of Health (IDOH) for 2 of 4 residents reviewed for falls with major injury. (Resident W and Resident T) Findings include: 1. During an interview on 1/17/25 at 1:21 P.M., Resident W indicated she fell at the facility and broke her hip. On 1/22/25 at 8:59 A.M., Resident W's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease. The most current Annual Minimum Data Set (MDS) Assessment, dated 12/3/24, indicated Resident W had moderate cognitive impairment, required substantial to maximal assistance of staff (staff does more than half) for bed mobility, toileting, and bathing, and had no falls since the prior assessment on 9/3/24. A change in condition note, dated 1/5/25 at 6:48 P.M., indicated Resident W had a fall due to altered mental status and was sent to the Emergency Room (ER) for evaluation and treatment. A health status note, dated 1/6/25 at 2:18 P.M.,		**same deficient practice will be identified and what corrective action will be taken:** 1 Other residents with a fall with injury have the potential to be affected. Any future falls with major injury will be reported per the guidelines. 2 Any resident has the potential to be affected. Staff in all departments will complete six hours of dementia training. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** 1 IDT reviewed the IDOH guidelines for reportable incidents to ensure that all are informed of and able to identify incidents requiring reporting. IDT will review all falls in clinical meetings five times per week to identify any falls with injuries that require reporting. Nurse managers on call will notify the ED of any suspected serious injuries related to falls. 2 Staff in all departments who are unable to show proof of training will complete the initial six hours of dementia training at this time. They will be removed from the schedule until completion is confirmed if not completed prior to 02/24/25. New hires will have the six hours of dementia training scheduled as part of their initial orientation.	

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	indicated Resident W returned from the hospital and imaging done at the hospital was normal. An alert note, dated 1/13/25 at 4:04 P.M., indicated after continued complaints of pain, the Nurse Practitioner (NP) ordered a repeat x-ray that showed an acute fracture of the distal femur, and the resident was sent to the ER for evaluation and treatment. Hospital discharge papers, dated 1/13/25 at 5:55 P.M., indicated the resident was being discharged with a primary diagnosis of fracture of distal end of femur, fracture of fibula, and tibial plateau fracture (right side). A nursing progress note, dated 1/13/25 at 7:22 P.M., indicated the resident returned to the facility with an immobilizer in place on her right leg. A review of Facility Reported Incidents for January 2025 lacked a report of this resident's fall. During an interview on 1/23/25 at 9:52 A.M., the Administrator indicated she did not report Resident W's fall with major injury to the State within 24 hours of the injury. 2. On 1/21/25 at 1:39 P.M., Resident T's clinical record was reviewed. Diagnoses included, but were not limited to, a Alzheimer's disease with late onset, nondisplaced fracture of greater tuberosity of right humerus, and other displaced fracture of upper end of right humerus. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 7/29/24, indicated the resident was not cognitively intact, required substantial to maximum assistance (staff does more than half) with toileting, showering/bathing, bed mobility, and transfers,		**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DNS or designee will audit all falls with major injury requiring reporting to ensure that the report is completed. An audit will be completed by ED or designee on 5 employee files per week to ensure completion of the required dementia training. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	

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	and had two or more falls with major injury since the last assessment. An SBAR (Situation Background Assessment and Recommendation) summary, dated 7/12/24 at 2:45 P.M., indicated that the resident was found on the floor in a common area by the nurses station. Resident T stated he had tripped over another resident's leg. Resident T reported pain to his right shoulder. No bruising or redness was noted. The resident was unable to lift his right arm by himself. The provider was notified and ordered an x-ray. A radiology report, dated 7/12/24, indicated Resident T had an impacted humerus neck fracture. An order note, dated 7/13/24 at 3:20 A.M., indicated x-ray results were reported to the Nurse Practitioner, and an order was received to transfer Resident T to the Emergency Room (ER) for evaluation and treatment. A nursing progress note, dated 7/13/24 at 12:58 A.M., indicated Resident T had arrived back to facility from the ER with a sling on his right arm and an order to follow up with Orthopedic Surgery in one week. A review of Facility Reported Incidents for July 2024 lacked a report of this resident's fall. During an interview on 1/23/24 at 10:52 A.M., the Administrator indicated they could not find a facility reported incident completed for Resident T's fall with major injury on 7/12/24. During an interview on 1/27/25 at 10:11 A.M., the Administrator indicated it was the policy of the			

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	facility to report falls with major injury to the State as required by the regulation. On 1/23/25 at 12:15 P.M., the Director of Nursing (DON) provided a current Assessing Falls and Their Causes policy, effective 8/2024, that indicated "Notify the following individuals when a resident falls: Report other information in accordance with facility policy and professional standards of practice". This citation relates to Complaint IN00448749. State Finding #2. 3.1-14 PERSONNEL (u) In addition to the required in-service hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to provide documentation of staff completing a minimum of three hours of dementia-specific training annually for 4 of 5 staff employed greater than 1 year reviewed and 3 of 5 staff reviewed for less than a year. (Qualified Medication Aide 1, Licensed Practical Nurse 3, Cook 5, Registered Nurse 7, Dietary 22, RN 9, and Certified Nurse Aide 11)			

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	Finding includes: On 1/24/25 at 1:00 P.M., employee files were reviewed. The following employees lacked documentation of dementia-specific training of six hours for staff employed less than a year and three hours for staff employed greater than a year: Qualified Medication Aide (QMA) 1 started employment with the facility on 1/8/24 and had no dementia inservice hours in 2024 and 2025. Licensed Practical Nurse (LPN) 3 started employment with the facility on 9/5/23 and had no dementia inservice hours since her hire date. Cook 5 started employment with the facility on 11/24/24 and had no dementia hours since her hire date. Dietary 22 started employment with the facility on 7/1/23 and had no dementia inservice hours in 2024 and 2025. Registered Nurse (RN) 9 started employment with the facility on 10/11/24 and had no dementia inservice hours since her hire date. RN 7 started employment with the facility on 7/1/23 and had no dementia inservice hours since her hire date. Certified Nurse Aide (CNA) 11 started employment with the facility on 8/21/24 and had no dementia inservice hours since her hire date. During an interview on 1/24/25 at 3:15 P.M., the Administrator indicated all employee inservices had been provided and if dementia hours were not			

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	listed, they were not done. During an interview on 1/27/25 at 12:31 P.M., the Administrator indicated that the facility did not have a policy related to dementia inservices specifically, but they followed the regulations as set forth by the State. On 1/27/25 at 12:31 P.M., the Administrator provided a current In-service Training, All Staff policy, revised 8/2024, that indicated " All staff must participate in initial orientation and annual in-service training... required training topics include...dementia management...".			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaints IN00446534, IN00446557, IN00448532, IN00448749, and IN00450264. Survey dates: January 16, 17, 21, 22, 23, 24, and 27, 2025 Facility number: 000439 Residential Census: 11 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance citedduring the Recertification and State Licensure with Complaint survey conducted January 27, 2025. Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 26, 2025. The provider respectfully requests desk review with paper compliance to	

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			be considered in establishing that the provider is in substantial compliance.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on interview and record review, the facility failed to ensure residents semi-annual evaluations and self-administration of medication evaluations were completed for 3 of 7 residents reviewed for physician evaluation (Resident 4, Resident 3, and Resident 5) and 5 of 5 residents reviewed for self administration of medications (Resident 2, Resident 4, Resident 3, Resident 5, and Resident 1) Findings include: 1. During an initial tour of the residential facility on 1/23/25 at 12:45 P.M., Licensed Practical Nurse (LPN) 19 indicated Resident 2 administered her own medications. On 1/24/25 10:17 A.M., Resident 2's clinical record was reviewed. Resident 2 was admitted on 12/11/24. Diagnoses included, but were not limited to, wound infection. The medication administration record indicated Resident 2 administered her own medications. The clinical record lacked a self-administration of medication evaluation. 2. During an initial tour of the residential facility on 1/23/25 at 12:45 P.M., Licensed Practical Nurse (LPN) 19 indicated Resident 4 administered her own insulin. On 1/24/25 at 10:32 A.M., Resident 4's clinical	R 0216	**R 216** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** A semi-annual evaluation was completed for residents 3, 4, and 5. A medication self-administration assessment was completed for residents 1, 2, 3, 4, and 5. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Residents in the Residential portion of the facility have the potential to be affected. All residents will have a semi-annual evaluation completed. All residents who self-administer medication will have a self-administration assessment completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**	02/26/2025

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	record was reviewed. Resident 4 was admitted on 7/1/23. Diagnoses included, but were not limited to, diabetes mellitus. The medication administration record indicated Resident 4 administered her own insulin medication. The clinical record lacked a self-administration of medication evaluation since 7/2/23. The clinical record lacked a semi-annual evaluation completed since 1/4/24. 3. During an initial tour of the residential facility on 1/23/25 at 12:45 P.M., Licensed Practical Nurse (LPN) 19 indicated Resident 3 administered her own medications. On 1/24/25 at 10:21 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, hypertension. Resident 3 was admitted to the facility on 11/1/22. The clinical record lacked a semi-annual evaluation completed since 11/27/23. The clinical record lacked a self administration of medication evaluation completed since 11/7/22. 4. During an initial tour of the residential facility on 1/23/25 at 12:45 P.M., Licensed Practical Nurse (LPN) 19 indicated Resident 5 administered her own medications. On 1/24/25 at 10:47 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, hypokalemia. Resident 5 was admitted to the facility on 11/23/21. The clinical record lacked a semi-annual evaluation completed since 4/5/24.		IDT was educated on the necessity to have a semi-annual evaluation and self-administration of medication assessment completed for Residential residents. IDT will review any new Residential admissions in clinical meetings five days a week to determine if the semi-annual evaluation and self-administration assessment were completed. A monthly audit will be completed and any assessments due in the next month will be scheduled for completion. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit will be completed monthly for all residential residents to determine if the semi-annual evaluation and the self-administration assessment are in compliance. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency**	

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	The clinical record lacked a self administration of medication evaluation completed since 11/23/21. 5. During an initial tour of the residential facility on 1/23/25 at 12:45 P.M., Licensed Practical Nurse (LPN) 19 indicated Resident 1 administered her own medications. On 1/24/25 at 9:28 A.M., Resident 1's clinical record was reviewed. Diagnoses included, but were not limited to, osteoporosis. Resident 1 was admitted to the facility on 7/3/21. The clinical record lacked a self administration of medication evaluation completed since 7/3/21. During an interview on 1/24/25 at 2:45 P.M., the Administrator indicated she was unable to find semi-annual evaluations for Resident 3, Resident 5, and Resident 2 or self administration of medication evaluations for Resident 1, Resident 2, Resident 3, Resident 4, and Resident 5. During an interview on 1/27/25 at 12:31 P.M., the Administrator indicated there was no policy related to semi-annual evaluations or self administration of medication evaluations, but the facility followed the regulations as set forth by the State. She expected a self administration of medication evaluation to be completed every six months when the service plans are updated. On 1/27/25 at 12:31 P.M., the Administrator provided a policy titled Self-Administration of Medications, dated 8/2024, that indicated "As part of the evaluation comprehensive assessment, the interdisciplinary team assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and		**will be completed:** February 26, 2025	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	clinically appropriate for the resident".			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure service plans were completed and signed by the resident every six months for 4 of 7 residents reviewed. (Resident 3, Resident 5, Resident 4, and Resident 6) Findings include: 1. On 1/24/25 at 10:21 A.M., Resident 3's clinical record was reviewed. Diagnoses included, but were not limited to, hypertension. Resident 3 was admitted to the facility on 11/1/22. The clinical record lacked a signed service plan completed since 11/17/23. 2. On 1/24/25 at 10:47 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, hypokalemia. Resident 5 was admitted to the facility on 11/23/21. The clinical record lacked a signed service plan completed since 4/5/24. 3. On 1/24/25 at 10:32 A.M., Resident 4's clinical record was reviewed. Resident 4 was admitted on 7/1/23. Diagnoses included, but were not limited to, diabetes mellitus. The clinical record lacked a service plan reviewed and signed in the past year. 4. On 1/24/25 at 10:48 A.M., Resident 6's clinical record was reviewed. Resident 6 was admitted on 3/4/24 and discharged on 12/13/24.	R 0217	**R 217** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Service plans were completed and signed by the resident for Residents 3, 4, and 5. Resident 6 was discharged from the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Residents in the Residential portion of the facility have the potential to be affected. All residents will have a semi-annual evaluation completed and signed by the resident. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** IDT was educated on the necessity to have a semi-annual evaluation completed and signed by the resident for Residential residents. IDT will review any new Residential	02/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 00 B. WING	01/27/2025

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	The clinical record lacked a service plan reviewed and signed between admission and discharge. During an interview on 1/24/25 at 2:45 P.M., the Administrator indicated she was unable to find signed service plans completed in the last year for Resident 3, Resident 5, Resident 4, and Resident 6. During an interview on 1/27/25 at 12:31 P.M., the Administrator indicated there was no policy related to service plans, but the facility followed the regulations as set forth by the State.		admissions in clinical meetings five days a week to determine if the semi-annual evaluation was completed and signed by the resident. A monthly audit will be completed and any assessments due in the next month will be scheduled for completion. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit will be completed monthly for all residential residents to determine if the semi-annual evaluation is completed and signed by the resident. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on interview and record review, the facility failed to ensure physician orders contained an	R 0409	**R 409** **What corrective action will be**	02/26/2025

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	annual health statement for 3 of 7 residents reviewed. (Resident 7, Resident 2, and Resident 6) Findings include: 1. On 1/24/25 at 10:57 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, hypertension. Resident 7 was admitted to the facility on 11/21/24. Resident 7 was discharged to a higher level of care on 12/13/24. The clinical record lacked an annual health statement for Resident 7. 2. On 1/24/25 10:17 A.M., Resident 2's clinical record was reviewed. Resident 2 was admitted on 12/11/24. Diagnoses included, but were not limited to, wound infection. The clinical record lacked an annual health statement for Resident 2. 3. On 1/24/25 at 10:48 A.M., Resident 6's clinical record was reviewed. Resident 6 was admitted on 3/4/24. The clinical record lacked an annual health statement for Resident 6. During an interview on 1/24/25 at 2:45 P.M., the Administrator indicated she was unable to find annual health statements for Resident 7, Resident 2, and Resident 6. During an interview on 1/27/25 at 12:31 P.M., the Administrator indicated there was no policy related to annual health statements, but the facility followed the regulations as set forth by the State.		**accomplished for those residents found to have been affected by the deficient practice:** Resident 6 and 7 have been discharged from the facility. An annual physician health statement has been included in the physician orders for Resident 2. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any resident in Residential care has the potential to be affected. All residents in Residential care have an annual health statement in their physician orders. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** IDT has been educated on the requirements for an annual physician health statement for residential residents. IDT will review any new Residential admissions in clinical meetings five days a week to determine if the annual physician health statement is in place. A monthly audit will be completed and any resident due for an updated annual physician health statement will be scheduled for completion.	

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			How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A monthly audit will be conducted on all Residential residents to determine that the annual health statement is in place. Results of the audit will be reviewed by QA team during QAPI meetings. POC may be revised or updated, based on QA review, as needed to achieve, and maintain compliance. Audits may be discontinued after six months with at least two consecutive months of 100% compliance achieved. **By what date the systemic changes for each deficiency will be completed:** February 26, 2025	