STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155803	A. BUILDING 00 B. WING	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMILTON POINTE HEALTH AND REHAB	3800 ELI PLACE NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00435563. Complaint IN00435563 - Federal deficiencies related to the allegations are cited at F684 and F9999. Survey dates: May 28, 29, 30, 31, June 3, 4, 5, 2024. Facility number: 012966 Provider number: 155803 AIM number: 201110390 Census Bed Type: SNF/NF: 71 SNF: 17 Residential: 53 Total: 141 Census Payor Type: Medicare: 9 Medicaid: 59 Other: 21 Total: 88 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 17, 2024.	F 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn Cates	Administrator	07/03/2024

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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	The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			

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	Based on observation, interview, and record review, the facility failed to ensure the privacy of residents was respected for 6 of 6 random observations and 1 of 1 insulin administrations observed. Staff did not knock on doors when entering, and left the door open when administering injections. (Resident D, Resident 45, Resident 37, Resident 6, Resident 7, Resident S, Resident 150) Findings include: 1. On 5/31/24 at 10:33 A.M., Registered Nurse (RN) 57 was observed to enter Resident 7's room without knocking. 2. On 5/31/24 at 10:35 A.M., RN 57 was observed to enter Resident S's room without knocking. 3. On 5/31/24 at 10:37 A.M., RN 57 was observed to enter Resident 150's room without knocking. 4. On 6/3/24 at 7:10 A.M., Qualified Medication Aide (QMA) 23 was observed to enter room 406 without knocking. From the hallway, QMA 23 was observed to administer two injections into Resident 45's abdomen. 5. On 6/3/24 at 7:16 A.M., QMA 23 was observed to enter Resident 37's room without knocking. 6. On 6/3/24 at 7:26 A.M., QMA 23 was observed to enter Resident D's room without knocking. 7. On 6/3/24 at 11:08 A.M., Licensed Practical Nurse (LPN) 19 was observed to administer an insulin injection to Resident 6. LPN 19 entered the room, raised the resident's shirt, and administered the insulin into the right side of the abdomen. LPN 19 did not shut the door or offer to shut the	F 0550	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. 2. All residents have the potential to be affected. 3. The Medication Administration policy was reviewed and no changes were indicated. Licensed staff and QMA's will be re-educated on this policy, which addresses knocking on doors and the provision of privacy. The DON or his designee will observe 10 medication passes on 10 random residents weekly for six weeks and until 100% compliance is achieved, then 10 per month for 6 months and until 100% compliance is maintained to ensure knocking on doors and privacy practices are in place. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	07/09/2024

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	door, and did not pull the curtain. On 6/5/24 at 8:15 A.M., RN 31 indicated staff should provide privacy for residents by closing the door and/or shutting the curtains when administering injections. Staff should also knock on the door and announce who they are when entering the rooms. On 6/5/24 at 12:09 P.M., the Director of Nursing (DON) indicated there was not a formal policy for privacy, but provided a current non-dated Nurse Aide Procedure check-off form that indicated "Knock and identify yourself before entering the resident's room. Wait for permission to enter the resident's room ... Maintains resident's right to privacy ... Close curtains, drapes, and doors ... Maintains resident's right to privacy and dignity" 3.1-3(a)			
F 0554 SS=E Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure residents who self administered medications were assessed for ability to self administer those medications for 4 of 4 random observations. Medications were observed in rooms where the resident lacked a self administration of medication assessment. (Resident 7, Resident S, Resident 150, Resident 6) Findings include: 1. On 5/30/24 at 9:39 A.M., Resident 7 was observed lying in bed with a box of throat	F 0554	The facility will ensure this requirement is met through the following corrective measures: 1. Residents 7, S, 150, and 6 were not harmed. Self-administration was discussed with the NP and those medications she identified those residents and medications she felt to be appropriate to keep at bedside. Those residents were assessed and the IDT met to review those assessments.	07/09/2024

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	lozenges lying at the foot of the bed. The box had a pharmacy label with the resident's name on it. On 5/31/24 at 9:41 A.M., Resident 7's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, depression, and psychotic disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/7/24, indicated a moderate cognitive impairment, and verbal behaviors directed toward others. Resident 7 required substantial to maximum assistance with transfers and bathing, and partial to moderate assistance with bed mobility. Current physician orders included, but were not limited to: Cepacol Sore Throat Mouth/Throat Lozenge (Menthol (Mouth-Throat)) Give 1 lozenge by mouth every hour as needed for for sore throat, dated 5/12/24. Resident 7 lacked an order related to having medications in room, or self administration of medications. Resident 7's clinical record lacked care plans related to having medications in room, or self administration of medications. Resident 7's clinical record lacked a self administration of medication assessment. On 5/31/24 at 10:33 A.M., Registered Nurse (RN) 57 was observed to enter Resident 7's room and identified the box of throat lozenges on the resident's bed as belonging to the resident. RN 57 indicated an order would have been needed to have the box in the room, left them in the room, and exited. At that time, RN 57 indicated he		Orders were obtained to keep those medications at the bedside. Those residents/medications deemed not appropriate were informed and medications were removed from the bedside. Care plans were updated accordingly. 2. All residents have the potential to be affected. No other residents were noted to have medications at the bedside without being appropriately assessed. 3. The policy for Medication Self-Administration was reviewed and no changes were indicated. Nursing staff will be educated on this policy. The DON or his designee will make rounds twice weekly for six weeks and until 100% compliance is achieved, then twice monthly for 6 months and until compliance is maintained to ensure no medications are self-administer/kept at bedside without proper assessment. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	assumed Resident 7's morning medications had been found in the room as well, because that morning the resident had refused to take them, and RN 57 indicated he left them in the room for the resident to take when she wanted to. 2. On 5/30/24 at 9:11 A.M., Resident S's room was observed with a bottle of fluticasone propionate (nasal spray) on the nightstand, with a label that indicated it belonged to Resident S. On 5/31/24 at 9:07 A.M., Resident S's clinical record was reviewed. Diagnosis included, but were not limited to, renal failure. The most recent Admission MDS (Minimum Data Set) Assessment, dated 4/1/24, indicated no cognitive impairment, and no behaviors. Resident S required partial to moderate assistance with bathing and bed mobility, and substantial to maximal assistance with toileting and transfers. On 5/31/24 at 10:08 A.M., Resident S's room was observed with the bottle of nasal spray on the nightstand. Current physician orders included, but were not limited to: Fluticasone Propionate Nasal Suspension, 1 spray alternating nostrils one time a day for allergies, dated 5/21/24. Resident 46 lacked an order related to having medications in room, or self administration of medications. Resident S's clinical record lacked care plans related to having medications in room, or self administration of medications. Resident S's clinical record lacked a self			

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	administration of medication assessment. On 5/31/24 at 10:35 A.M., RN 57 indicated Resident S had an order to have the nasal spray in her room on a previous admission, but was unsure if there was a current order or not. At that time, RN 57 was observed to enter Resident S's room and acknowledge the nasal spray at bedside. RN 57 left the room, leaving the nasal spray. 3. On 5/30/24 at 10:16 A.M., Resident 150 was observed sitting in his room. On the nightstand an inhaler for spiolto respimat was observed. No label was observed on the inhaler. At that time, Resident 150 indicated he used the inhaler every morning. On 5/31/24 at 10:59 A.M., Resident 150's clinical record was reviewed. Diagnosis included, but were not limited to, shortness of breath and wheezing. The most recent Admission MDS (Minimum Data Set) Assessment, dated 5/23/24, indicated no cognitive impairment and no behaviors. Current physician orders included, but were not limited to: Acetaminophen (Tylenol) Oral Tablet (Acetaminophen) 650 mg (milligrams) by mouth every 6 hours as needed for pain dated 5/21/24. Resident 150's clinical record lacked a current order for a spiolto respimat inhaler. On 5/31/24 at 11:37 A.M., RN 57 was observed to enter Resident 150's room and located the spiolto respimat inhaler on the bed, and a bottle of unlabeled Tylenol in the nightstand drawer. At that time, RN 57 indicated the resident would have needed a self administration order to have the			

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medications in his room, and was unsure if there was one. RN 57 left the room, leaving the medications in the room.

Resident 150 lacked an order related to having medications in room, or self administration of medications.

Resident 150's clinical record lacked care plans related to having medications in room, or self administration of medications.

Resident 150's clinical record lacked a self administration of medication assessment.

On 5/31/24 at 10:29 A.M., the Unit Manager indicated she was unsure what the policy was for medications in resident rooms, but would expect the staff to take them out of the rooms if observed. She indicated normally, the resident would have an order and assessment to self administer medications, and an order to keep at bedside.

4. On 5/29/24 at 2:39 P.M., 2 2-oz (ounce) bottles of glucose shots were observed on Resident 6's bedside table. Resident 6 indicated she took the glucose shots when she felt like her blood sugar was low.

On 5/30/24 at 2:24 P.M., 2 2-oz bottles of glucose shots were observed on Resident 6's bedside table.

On 6/3/24 at 10:14 A.M., 2 2-oz bottles of glucose shots were observed on Resident 6's bedside table.

On 5/30/24 at 2:31 P.M., Resident 6's clinical record was reviewed. Diagnosis included, but was

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	not limited to, type 2 Diabetes Mellitus. The most recent Annual MDS (Minimum Data Set) Assessment, dated 4/28/24, indicated Resident 6 was cognitively intact, required setup assistance for eating, and received a hypoglycemic medication during the 7-day lookback period. Physician orders included, but were not limited to: Glucose Oral Solution (Glucose) - Give 30 ml (milliliters) by mouth every 8 hours as needed for blood glucose <70 may have up to three times daily, dated 2/1/24. The clinical record lacked a self-administration of medication evaluation. On 6/4/24 at 8:26 A.M., LPN (Licensed Practical Nurse) 19 indicated Resident 6 did not have a self-administration of medication order or evaluation for the glucose shots. On 6/4/24 at 2:54 P.M., the Regional Clinical Nurse indicated there was no self-administration of medication evaluation in Resident 6's clinical record. On 5/31/24 at 11:44 A.M., RN (Registered Nurse) 35 provided a current Resident Self-Administration of Medication policy, dated 11/1/23, that indicated "A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely ... The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record ... The care plan must reflect resident self-administration and			

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	storage arrangements...". 3.1-11(a)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure the MDS (Minimum Data Set) Assessment was completed accurately for 2 of 5 residents reviewed for unnecessary medications. (Resident 6, Resident 7) Findings include: 1. On 5/30/24 at 2:31 P.M., Resident 6's clinical record was reviewed. Diagnosis included, but was not limited to, malignant neoplasm of descending colon. The most recent Annual MDS (Minimum Data Set) Assessment, dated 4/28/24, indicated Resident 6 was cognitively intact and did not receive an opioid during the 7-day lookback period. Physician orders included, but were not limited to: fentanyl (an opioid medication) patch 12 MCG/HR (micrograms per hour) - Apply 1 patch transdermally every 72 hours for pain and remove per schedule, dated 11/3/23. oxycodone-acetaminophen (an opioid medication) tablet 5-325 MG (milligrams) - Give 1 tablet by mouth three times a day for pain and give 1 tablet by mouth as needed for pain may have up to two additional doses daily. PRN (as needed) dose may not be within 2 hours of last routine dose, dated	F 0641	The facility will ensure this requirement is met through the following corrective measures: 1. Residents 6 and 7 were not harmed. Those inaccurate sections of MDS's have been corrected. 2. All residents have the potential to be affected. The past 30 days of assessments were reviewed to ensure accuracy with medication coding. Corrections have been made when indicated. 3. The facility utilizes the RAI Manual as policy. The MDS staff will be educated on MDS accuracy. The MDS Coordinator or her designee will randomly audit 3 MDS's weekly for 6 weeks and until 100% compliance is achieved, then 5 per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	07/09/2024

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	1/12/24 and discontinued on 4/29/24. The April 2024 MAR (Medication Administration Record) indicated Resident 6 received oxycodone-acetaminophen three times daily on April 22, 23, 24, 25, 26, and 28 and two times on April 27. The April 2024 MAR indicated Resident 6 had a fentanyl patch placed on April 22, 25, and 28. On 6/4/24 at 1:11 P.M., MDS Coordinator 15 indicated that Resident 6's MDS dated 4/28/24 should have indicated the resident received opioids during the 7-day lookback period. On 6/4/24 at 1:11 P.M., MDS Coordinator 15 indicated the facility followed the RAI (Resident Assessment Instrument) Manual for guidance in coding MDS Assessments. 2. On 5/31/24 at 9:41 A.M., Resident 7's clinical record was reviewed. Diagnosis included, but were not limited to, history of CVA (cerebrovascular accident). The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/7/24, indicated a moderate cognitive impairment. Resident 7 was marked as not receiving an antiplatelet medication. Current physician orders included, but were not limited to: clopidogrel bisulfate (an antiplatelet) tablet 75 mg (milligram), give 1 tablet by mouth one time a day for preventative, history of CVA, dated 1/25/24 Resident 7's MAR (Medication Administration Record) for May 2024 indicated clopidogrel was administered in the 7-day look back period for the 5/7/24 Quarterly MDS Assessment.			

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	On 6/5/24 at 11:22 A.M., MDS Coordinator 89 indicated Resident 7's MDS on 5/7/24 was marked in error and should have indicated the resident received an antiplatelet. She indicated at that time that there was not a facility policy for MDS Assessments, and that the policy was to follow the RAI (Resident Assessment Instrument) manual.			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.			

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	(iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to ensure physician orders were followed for 2 of 2 residents reviewed for nutrition. (Resident 55 and Resident S) Findings include: 1. On 5/31/24 at 12:22 P.M., Resident 55's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and epilepsy. The most recent Annual MDS (Minimum Data Set) Assessment, dated 4/18/24, indicated Resident 55 was moderately cognitively intact, required setup assistance from staff for eating, had a feeding tube, had an unplanned weight loss, and was receiving a mechanically altered diet. Physician orders included, but were not limited to: Weekly weights for trending weight loss one time a day every Saturday for trending weight loss, dated 2/17/24.	F 0656	The facility will ensure this requirement is met through the following corrective measures: 1. Residents 55 and S were reviewed by the IDT. The NP and dietician were notified of the documentation omissions. Both nutrition regimens and weights were reviewed and altered as indicated. 2. All residents have the potential to be affected. 3. The policies on Weight Monitoring, Care Planning, and Following Physician's Orders/Parameters were reviewed and no changes were indicated. Licensed nursing staff and QMA's will be educated on these policies. The DON or his designee will audit EMAR's	07/09/2024

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	155803	A. BUILDING 00 B. WING	06/05/2024

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	2-Cal HN (liquid nutritional supplement) 300 mL (milliliters) bolus (administer full amount at once) four times a day, dated 5/23/24- current. 2-Cal HN 300 mL bolus four times a day, dated 5/2/24-5/23/24. Jevity 1.5 (liquid nutritional supplement) 300 mL bolus feeding four times a day before meals and at bedtime, dated 4/15/24-5/1/24. Jevity 1.5 (liquid nutritional supplement) 300 mL bolus feeding four times a day before meals and at bedtime, dated 2/29/24-4/15/24. Jevity one carton (237 mL) bolus feeding four times daily before meals and at bedtime, dated 7/27/23-2/29/24. Recorded weights for the last six months, that indicated a weight loss greater than 10% (10.65%), included: 12/1/23 124 pounds 6/2/24 110.8 pounds The following dates and times indicated the physician order for nutritional supplement was not administered during the last six months, and did not include a descriptive reasoning for the missed administration of nutritional supplement: 2/23/24 9 P.M. 2/27/24 9 P.M. 3/3/24 9 P.M. 3/30/24 9 P.M. 4/3/24 9 P.M. 4/4/24 11 A.M. 4/13/24 9 P.M. 4/14/24 9 P.M. 4/15/24 11 A.M. 4/22/24 11 A.M., 5 P.M. 4/26/24 11 A.M. 5/7/24 bedtime 5/13/24 bedtime 5/20/24 bedtime		weekly to ensure orders are followed for 6 weeks and until 100% compliance is achieved, then twice monthly for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	5/27/24 9 P.M. 6/4/24 1 P.M. On 6/5/24 at 1:12 P.M., the Director of Nursing provided a current policy titled Following Physician Orders, revised 4/24, and indicated Licensed healthcare personnel will consult and follow the physician/clinician order when performing any resident procedures. 2. On 5/31/24 at 9:07 A.M., Resident S's clinical record was reviewed. Diagnosis included, but were not limited to, renal failure. The most recent Admission MDS (Minimum Data Set) Assessment, dated 4/1/24, indicated no cognitive impairment, and no behaviors. Resident S was receiving a therapeutic diet with no weight loss or gain. Current physician orders included, but were not limited to: Obtain weight daily **before dialysis** one time a day, notify physician of gain of more than 3 pounds in a day or 5 pounds in a week, dated 5/23/24. Discontinued physician orders included, but were not limited to: Obtain weight daily, one time a day, notify physician of gain of more than 3 pounds in a day or 5 pounds in a week, dated 5/22/24 through 5/22/24. Obtain weight daily, one time a day, notify physician of gain of more than 3 pounds in a day or 5 pounds in a week, dated 5/21/24 through 5/21/24. Obtain weight daily x 3 days, every day shift for 3 days, dated 5/21/24.			

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	Obtain weight daily in AM, one time a day, notify physician of gain of more than 3 pounds in 24 hours or > 5 pounds in 72 hours., dated 5/1/24 through 5/14/24. Obtain weight daily, one time a day, dated 4/30/24 through 4/30/24. Obtain weight one time a day, notify physician of gain of more than 3 pounds in 24 hours or 5 pounds in 72 hours, dated 4/27/24 through 4/29/24. Obtain weight every AM, one time a day, notify physician of gain of more than 3 pounds in 24 hours or 5 pounds in 72 hours, dated 4/7/24 through 4/24/24. Obtain weight one time a day, notify physician of gain of more than 3 pounds in 24 hours or 5 pounds in 72 hours, dated 3/29/24 through 4/6/24. A current dialysis care plan, initiated 5/21/24, included, but was not limited to, an intervention to weigh and get vital signs as ordered and as needed, also dated 5/21/24. Resident S was not in the facility on the following dates: 4/2/24 4/21/24 through 4/26/24 5/14/24 through 5/20/24 Resident S's clinical record lacked weights on the following dates from 3/28/24 through 5/31/24: 3/29/24 3/30/24 (recorded as 128.8, then crossed out 4/2/24 as "error") 4/1/24			

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	4/3/24 4/6/24 4/7/24 (recorded as 105.2, then crossed out 4/11/24 as "re-weighed". No re-weigh documented) 4/8/24 (recorded as 104.8, then crossed out 4/11/24 as "re-weighed". No re-weigh documented) 4/12/24 4/16/24 4/18/24 (recorded as 122.2, then crossed out 5/9/24 as "re-weighed". No re-weigh documented) 4/27/24 4/28/24 4/29/24 5/1/24 5/2/24 5/5/24 (recorded as 109.4, then crossed out 5/9/24 as "re-weighed". No re-weigh documented) 5/7/24 5/8/24 5/9/24 5/13/24 5/25/24 5/26/24 (marked as "n/a") 5/27/24 5/31/24 On 6/5/24 at 8:00 A.M., the Unit Manager indicated the dietician must have deleted Resident S's weights on 4/18/24 and 5/5/24 because those weights didn't match what the surrounding days had been. She indicated staff would discuss weights at morning meeting, and mark out the weights that were obtained that did not seem normal for that resident. On 6/5/24 at 11:05 A.M., the Director of Nursing (DON) indicated there was not a formal policy for following orders or care plans, but staff should be following interventions and orders as ordered.			

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	3.1-35(b)(1)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to provide care by thorough assessment of a resident prior to narcotic medication administration and implementation of a person centered care plan for the use of narcotics, and a care plan that reflected accurate resuscitative measures for 1 of 2 residents reviewed for expiration in the facility. (Resident P) Findings include: On 6/3/24 at 9:15 A.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, asthma and atrial fibrillation. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 4/1/24, indicated Resident P was cognitively intact and was receiving opioid pain medication during the seven day lookback period. Physician orders included, but were not limited to: Do not resuscitate, dated 2/9/24. Observe for side effects (Narcotic pain medication), dated 2/15/24. Ipratropium-albuterol (medication to improve	F 0684	The facility will ensure this requirement is met through the following corrective measures: 1. Resident P no longer resides at the facility. 2. All residents have the potential to be affected. Code status care plans have been removed and the code status has been incorporated into the Choices care plan. Those residents receiving opioid narcotics were reviewed to ensure a care plan to address the potential for adverse effects was in place. A pain medication order audit was completed to ensure that staff are prompted to assess pain level prior to administration. 3. The policies on Care Planning & Pain Management were reviewed and no changes were indicated. Licensed nursing staff will be educated on those policies. The DON or his designee will review 5 random residents twice weekly to ensure	07/09/2024

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	breathing) inhalation solution 0.5-2.5(3) mg/mL (milligram per milliter) one inhalation inhale orally every eight hours as needed, dated 2/27/24. Norco (opioid pain medication) oral tablet 5-325 mg (Hydrocodone-Acetaminophen) Give one tablet by mouth three times a day for pain hold for sedation, dated 4/15/24. Norco oral tablet 5-325 mg (Hydrocodone-Acetaminophen) Give one tablet by mouth every four hours as needed for pain, dated 4/15/24. Resident P's clinical record included a signed document Titled Indiana Physician Orders for Scope of Treatment (POST), dated 2/9/24, and indicated Medical Interventions Comfort Measures (Allow Natural Death). Care plans included, but were not limited to: I have elected to be a full code, dated 2/9/24. I have chronic breathing problems related to asthma; observe for increased shortness of breath, difficulty breathing, change in mental status.., dated 3/21/24. The clinical record lacked a care plan relating to narcotic pain medications and potential adverse side effects to monitor. On 6/3/24 at 9:15 A.M., Resident P's medication administration record was reviewed. Resident P narcotic sheet indicated on 4/23/24 Norco 5-325 mg was given at 6:35 A.M., 9:00 A.M., 1:00 P.M., 5:00 P.M., and 8:00 P.M. A progress note dated 4/23/24 at 5:16 P.M., indicated Resident was given a breathing treatment and oxygen saturation level had come back to 89% on 2L (liters).		assessment is completed prior to administration and that potential side effects are being monitored at least once per shift for 6 weeks and until 100% compliance is achieved, then 10 residents per month for 6 months and until 100% compliance is maintained. The DON or his designee will review 5 random residents twice weekly to ensure potential side effect care plans are in place for 6 weeks and until 100% compliance is achieved, then 10 residents per month for 6 months and until 100% compliance is maintained. The Social Services Manager or his designee will review 6 random resident's care plans weekly to ensure accurate code status is addressed in the Choices care plan for 6 weeks and until 100% compliance is achieved, the 10 per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	A progress note dated 4/23/24 at 6 P.M., indicated Resident P's family member had notified staff of the resident's symptoms. Vitals checked and oxygen saturation dropped to 68%. Resident was placed on 2L oxygen by nasal cannula. Resident declined going to the hospital. Staff set an acute visit for the following day. A progress note dated 4/23/24 at 7:17 P.M., indicated LPN 45 took bedtime medications to Resident P, and resident was unable to rouse or swallow medications. EMS and family were called, the Physician was notified through Telemedic. Ambulance arrived followed by the Fire Department. Blood glucose level had dropped, and an intravenous line was started by EMS in Resident P's left shin bone. At 8:08 P.M., Resident P stopped breathing. CPR (cardio-resuscitation) was not started. On 6/5/24 at 8:43 A.M., LPN 45 stated Resident P's oxygen level was at 68% prior to the breathing treatment of albuterol administered on 4/23/24 at 5:16 P.M. The Norco 5-325 tablet was signed out at 8:00 P.M., but should have been signed out at 7:17 P.M. with the other bedtime medications; Resident did not take any of the bedtime medications due to inability to swallow, the medications rolled out when a spoonful was placed in Resident P's mouth. Prior to 7:17 P.M., Resident P was completely alert and oriented, and having a full conversation. Resident P had no adverse signs, symptoms, or side effects other than nausea and respiratory changes. EMS (emergency medical services) and fire department arrived at the facility quickly; LPN 45 indicated she was not sure what Resident P's blood sugar was when EMS checked it, Resident was not a regular blood sugar check and did not receive insulin. Nurse indicated she probably should have			

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	revised charting and struck out the medications out for the eMAR (electronic medication administration record) to reflect the resident not taking the medications, but it was a chaotic night and staff were doing their best to get everyone caught up and the rest of the resident's taken care of. During an interview on 6/5/24 at 10:22 A.M., Regional Clinical Nurse 9 indicated in order for a nurse to recognize respiratory distress, it would have to be more than just low oxygen levels, and the resident did not have an order for oxygen but staff can administer oxygen in emergent situations without an order. During an interview on 6/5/24 at 11:38 A.M., Regional Clinical Nurse 9 indicated the care plan that indicated Resident P was a full code was inaccurate and should have indicated do not resuscitate, there was not a care plan related to pain medication side effects, and the facility did not have a policy relating to monitoring adverse side effects of narcotic pain medications. This citation relates to complaint IN00435563. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices			

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	to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure post fall assessments were completed and care plans were updated to prevent falls for 2 of 4 residents reviewed for accidents. (Resident 40, Resident 83) Findings include: 1. On 5/30/24 at 2:18 P.M., Resident 40 was observed in bed. There was one set of non-skid strips near her bed. On 5/30/24 at 1:26 P.M., Resident 40's clinical record was reviewed. Diagnoses included, but were not limited to, vascular dementia, fracture of fifth metacarpal bone right hand, and history of falling. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/16/24, indicated Resident 40 had moderate cognitive impairment, required supervision of staff for sit to stand transfers and toileting, partial to moderate assistance of staff for bathing, and had one fall with no injury since the prior assessment. A fall risk assessment, dated 3/15/24, indicated Resident 40 was at low risk for falls. A current falls care plan, revised 1/22/24, indicated the resident was at risk for falls. The interventions included, but were not limited to: I am going to wear proper footwear or non-slip footwear when I am up, dated 4/2/21 The clinical record indicated Resident 40 fell 7 times since 9/27/24. Fall 1	F 0689	The facility will ensure this requirement is met through the following corrective measures: 1. Residents 40 and 83 were not harmed. Their care plans were reviewed and revised accordingly. 2. All residents have the potential to be affected. Falls for the past 30 days were reviewed to ensure care planned interventions are appropriate and in place. 3. The Fall Investigation and Risk Evaluation policy was reviewed and no changes were indicated. Licensed nursing staff will be educated on this policy. The DON or his designee will complete audits of post-fall assessments 5 days weekly to ensure they are completed for 6 weeks and until 100% compliance is achieved, then twice weekly for 6 months and until 100% compliance is maintained. The DON or his designee will audit fall care plans post-fall 5 days a week to ensure they are updated with an appropriate intervention for 6 weeks and until 100% compliance is achieved, then twice weekly for 6 months and until 100% compliance is achieved. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	07/09/2024

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	9/24/23 at 8:20 P.M. Fall was not witnessed. The resident indicated she fell while trying to transfer from the toilet to her chair. The resident had 3 small skin tears to her right lower extremity. Neurological assessments were completed. Intervention "medication review and therapy referral" was added to the care plan on 9/28/23. Fall 2 9/28/23 at 1:45 P.M. Fall was witnessed. The resident indicated she was picking something up off the floor. Intervention "Give resident a reacher to retrieve things on the floor" was added to the care plan on 9/29/23. Fall 3 12/23/23 at 7:45 A.M. Fall was unwitnessed. The resident indicated she lost her balance after using the toilet. Neurological assessments were completed. Intervention "call don't fall sign placed in room" was added to the care plan on 12/26/23. Fall 4 1/10/24 at 3:20 P.M. Fall was witnessed. The resident was attempting to self-transfer between her bed and her wheelchair. Intervention "add non-skid strips next to bed" was added to the care plan on 1/11/24. Fall 5 1/19/24 at 12:30 P.M. Fall was unwitnessed. The resident was attempting to self-transfer from her bed to her wheelchair. The resident broke her glasses in the fall and sustained a laceration to her right eye. The NP (Nurse Practitioner) was notified, and the resident was sent to the Emergency Room (ER) where she received sutures to her right eye and a fracture to her fifth metacarpal was identified. The resident returned to the facility at 7:29 P.M. on 1/19/24. Intervention			

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	"Assist resident up in her wheelchair and down to the dining room for meals" was added to the care plan on 1/22/24. Fall 6 2/6/24 at 4:00 P.M. Fall was witnessed. The resident indicated she fell while attempting to sit on her bed. Intervention "New gripper socks added, add additional non-skid strips next to bed" was added to the care plan on 2/7/24. Fall 7 5/9/24 at 12:35 P.M. Fall was unwitnessed. The resident attempted to self-transfer from her wheelchair to the toilet. Neurological assessments were incomplete. No neurological assessments were documented after 5/10/24 at 4:15 A.M. Intervention "add cushion to secure to wheelchair with buckle/strap" was added to the care plan on 5/10/24. 2. On 6/3/24 at 8:58 A.M., Resident 83's clinical record was reviewed. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side and muscle weakness. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 4/22/24, indicated Resident 83 had moderate cognitive impairment, required supervision for sit to stand transfers and partial to moderate assistance of staff for toileting and bathing, and had no falls since re-entry to the facility. A re-entry falls assessment, dated 4/15/24, indicated the resident was at high risk for falls. A falls care plan, revised 4/15/24, indicated the resident was at risk for falls related to weakness.			

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Progress notes indicated the resident fell on 4/12/24 at 3:30 P.M. Fall was unwitnessed. The resident was found on the floor in his room with his "head cupped in hand". The resident indicated he was attempting to go to the bathroom. A neurological assessment was completed on 4/12/24 at 3:30 P.M. and on 4/13/24 at 12:04 A.M. No other neurological assessments were documented. Intervention "Add cupholder to wheelchair" was added to the care plan on 4/15/24.

Progress notes indicated the resident fell on 4/13/24 at 2:15 A.M. Fall was unwitnessed. The resident indicated he was attempting to go to the bathroom. No apparent injury was noted. The resident was sent to the Emergency Room (ER) for evaluation at 3:23 A.M. No neurological assessments were documented. An Interdisciplinary Team (IDT) note, dated 4/15/24 at 8:52 A.M., indicated the resident would be reassessed upon return from the hospital. A new intervention was not added to the care plan.

On 6/4/24 at 9:20 A.M., the Director of Nursing (DON) indicated that when a resident fell, they were assessed for injuries and the risk management tool was filled out. Neurological assessments were completed per policy for any unwitnessed falls or suspected head injuries and documented in the electronic medical record (EMR). Staff could write their neurological assessments on paper, but then should transfer them into the EMR. IDT would review the fall and update the care plan with a new and relevant intervention after every fall.

On 6/4/24 at 10:29 A.M., Medical Records employee provided a current Fall Investigation

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	and Risk Evaluation policy, revised 6/22, that indicated "Neuro checks if the fall was unwitnessed or an injury to the head is suspected or observed ... Update the care plan with new intervention(s)...". On 6/4/24 at 1:46 P.M., the DON provided a current Neurological Assessment Protocol policy, revised 12/21, that indicated "Neurological assessments should be performed as follows for a 72 hour period: every 15 minutes x4, every 30 minutes x2, every 1 hour x2, every 4 hours x1, every 8 hours x8". 3.1-45(a)(2)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to ensure pain management consistent with professional standards of practice, care plans, and the resident's goals and preferences were provided for 2 of 2 residents reviewed for pain management. A resident was not monitored for side effects of narcotic pain medication resulting in an overdose, pain medication was not given as prescribed, and a resident's preference for non-pharmacological pain relief was not honored. (Resident T, Resident 6) Findings include:	F 0697	The facility will ensure this requirement is met through the following corrective measures: 1. Resident P no longer resides at the facility. Resident T's pain was re-evaluated. An order has been obtained that the resident may utilize a disposable hot pack every 4 hours as needed to assist with non-pharmacological pain management. Her plan of care was reviewed and revised. 2. All residents have the potential to be affected. Code status care plans have been removed and the	07/09/2024

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	1. On 5/30/24 at 9:52 A.M., Resident T indicated she had arthritis and gout, and was in constant pain. She indicated she received medications for pain, but it did not help much. On 5/31/24 at 9:46 A.M., Resident T's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety and leg pain. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/5/24, indicated no cognitive impairment, and no behaviors. Resident T required supervision with bed mobility and toileting, and partial to moderate assistance with bathing. Resident T received scheduled pain medications, and had experienced occasional moderate pain for the previous five days. Physician orders included, but were not limited to: Norco (Hydrocodone-Acetaminophen) (a narcotic pain medication) 10-325mg (milligram), give 1 tablet 5 times a day for pain, with instructions to use 5mg until the 10mg arrive, started 9/14/23 and discontinued 11/1/23. Norco 10-325mg, give 1 tablet 5 times a day for pain, with instructions to discontinue Norco 10mg when supply complete, started 11/1/24 and discontinued 11/2/23. Norco 5-325mg, give 2 tablets by mouth 5 times a day, with instructions to discontinue Norco 10/325 order when this supply completed, new order entered for 5/325 2 tabs 5 times a day, started 11/2/23 and discontinued 11/2/23. Norco 5-325mg, give 2 tablets by mouth 5 times a day, started 11/2/23 and discontinued 12/25/23. Norco 5-325mg, give 2 tablets by mouth 5 times a day, started 12/30/23 and discontinued 1/1/24.		code status has been incorporated into the Choices care plan. Those residents receiving opioid narcotics were reviewed to ensure a care plan to address the potential for adverse effects was in place. A pain medication order audit was completed to ensure that staff are prompted to assess pain level prior to administration. Pain assessments were reviewed and re-evaluation was completed as indicated. Care plans were reviewed to ensure any resident preferences were included. 3. The policies on Care Planning & Pain Management were reviewed and no changes were indicated. Licensed nursing staff will be educated on those policies. The DON or his designee will review 5 random residents twice weekly to ensure assessment is completed prior to administration and that potential side effects are being monitored at least once per shift for 6 weeks and until 100% compliance is achieved, then 10 residents per month for 6 months and until 100% compliance is maintained. The DON or his designee will review 5 random residents twice weekly to ensure potential side effect care plans are in place, pain care plans include resident preferences when indicated, and pain evaluations are thorough and accurate for 6 weeks and until 100% compliance is achieved,	

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	Norco 5-325mg, give 2 tablets as needed for pain 5 times a day, started 1/6/24 and discontinued 1/9/24. Norco 5-325mg, give 1 tablet as needed for pain 5 times a day, started 1/9/24 and discontinued 1/22/24. Norco 5-325mg every 12 hours as needed for pain, started 2/9/24 and discontinued 3/18/24. Oxycodone (a narcotic pain medication) 5mg, give 1 tablet by mouth every 6 hours as needed for pain, started 3/28/24 and discontinued 4/22/24. Oxycodone 5mg, give 1 tablet every 4 hours as needed for pain, started 4/24/24 and discontinued 5/5/24. Oxycodone 5mg, give 1 tablet every 4 hours as needed for pain, started 5/12/24 and discontinued 5/15/24. Oxycodone 5mg, give 1 tablet by mouth every 4 hours as needed for pain, started 5/18/24 and currently an active physician order. Observe for side effects of narcotic pain medication every 12 hours for pain, dated 5/20/24. The original order for narcotic monitoring was dated 1/5/24. Resident T's MAR (Medication Administration Record) indicated when Norco 5-325mg was ordered to be given five times a day, it was to be given at 2:00 A.M., 9:00 A.M., 1:00 P.M., 5:00 P.M., and 9:00 P.M. A current risk for pain care plan, dated 7/7/21 and		then 10 residents per month for 6 months and until 100% compliance is maintained. The Social Services Manager or his designee will review 6 random resident's care plans weekly to ensure accurate code status is addressed in the Choices care plan for 6 weeks and until 100% compliance is achieved, the 10 per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	revised 6/19/23, indicated pain medication would be administered as ordered and requested, dated 7/7/21. A current opioid medication care plan, dated 11/14/22, indicated but was not limited to, the following interventions: To receive medication as prescribed, dated 11/14/22. Adequately monitor dose, duration and indication of use, dated 11/14/22. Assess pain, dated 11/14/22. Quarterly pain evaluations from 11/2023 through current included, but were not limited to, the following: 12/21/23 The evaluation was not complete. 1/5/24 The evaluation was not complete. 5/12/24 The evaluation was not complete. On 12/30/24, Resident T was sent to the hospital following an episode of altered mental status per family request. In the emergency room, the resident was minimally responsive to painful stimuli, and kept falling asleep. Because the resident was not able to protect her airway, she was intubated. The resident was administered Narcan (an opiate blocker) and rapidly improved, awoke and was communicating meaningfully. The resident was then admitted to the hospital on an infusion of Narcan. The admitting diagnosis was unintentional narcotic overdose and recent COVID infection, and the resident discharged back to the the facility on 1/5/24. Narcotic sign out forms for Norco 5-325mg from			

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	11/2023 to current were reviewed with the following dates and times one tablet was retrieved when the physician order was for two tablets: 11/11/23 at 2:00 A.M. 11/11/23 at 3:00 P.M. 11/11/23 at 8:00 P.M. 11/12/23 (unreadable time) 11/12/23 at 5:00 P.M. 11/12/23 at 8:00 P.M. 11/17/23 at 8:00 A.M. 11/17/23 at 1:00 P.M. 11/24/23 at 9:00 P.M. 12/23/23 at 8:00 A.M. Resident 31's clinical record lacked a reason why one tablet was given rather than the two tablets that were ordered. Narcotic sign out forms for Norco 5-325mg from 11/2023 to current included the following dates and times two tablets were retrieved when the physician order was for one tablet: 1/9/24 at 8:00 P.M. 1/15/24 (unreadable time) 1/16/24 at 8:00 P.M. 1/17/24 (unreadable time) 1/18/24 at 7:43 P.M.			

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	The Norco sign out forms indicated the following doses that were given within 2.5 hours of each other: 11/23/23 at 5:30 P.M. then again on 11/23/23 at 8:00 P.M. (two 5mg tablets with each administration). 11/30/23 at 10:30 A.M. then again on 11/30/23 at 1:00 P.M. (two 5mg tablets with each administration). On 6/4/24 at 2:06 P.M., the Director of Nursing (DON) indicated Resident T should have been monitored for narcotic side effects prior to the hospitalization on 12/30/23, but the monitoring was put into place in 1/2024. He further indicated he was unsure why staff was only giving Resident T one tablet of Norco when two were ordered. On 6/5/24 at 11:05 A.M., the DON indicated the facility did not have a policy specific to following orders, but the policy would be to follow physician orders. On 6/4/24 at 2:21 P.M., a current Medication Administration policy, dated 2/1/18, was provided and indicated "Follow the six (6) rights of medication administration ... right dose ... right time ... right documentation .... Medication(s) are to be administered no sooner than sixty (60) minutes prior and no later than sixty (60) minutes after scheduled time" On 6/5/24 at 12:09 P.M., a current Medication Monitoring policy, dated 11/1/23, was provided and indicated "This facility takes a collaborative, systematic approach to medication management, including the monitoring of medications for efficacy and adverse consequences".			

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	2. On 5/29/24 at 2:50 P.M., Resident 6 indicated she was in constant pain and took pain medication, but the facility would not let her have a heat pad or offer her an alternative like a warm washcloth or rice pack. A heat pad was what she used at home to help with arthritis pain, and it worked better than the pills for that pain. On 5/30/24 at 2:31 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, malignant neoplasm of descending colon, anxiety disorder, and depression. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/28/24, indicated Resident 6 was cognitively intact, required setup assistance for eating, received scheduled and PRN (as needed) pain medication, and had no behaviors. A current opioid medication care plan, dated 4/12/24, included an intervention to participate in non-pharmacological approaches to pain reduction. A current acute pain care plan, dated 11/1/23, indicated the resident had all over pain complaints. Physician orders included, but were not limited to: fentanyl (an opioid pain medication) patch 12 MCG/HR (micrograms per hour) - Apply 1 patch transdermally every 72 hours for pain and remove per schedule, dated 11/3/23 Oxycodone-acetaminophen tablet 5-325 MG (milligrams) - Give 1 tablet by mouth three times a day for pain and give 1 tablet by mouth as needed			

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	for pain may have up to two additional doses daily. PRN dose may not be within 2 hours of last routine dose, dated 4/29/24 The most recent quarterly pain evaluation assessment, dated 5/1/24, indicated Resident 6 had pain at a level 5 (on a 1 to 10 pain scale). The assessment included a section to indicate methods of preferred pain relief, but it had not been completed. A behavior note, dated 5/22/23, indicated that staff had taken a heating pad away from the resident and "reminded her that she had been told many times that she could not have a heating pad in her room". A progress note, dated 6/6/23 at 10:47 A.M., indicated the resident stated she had pain constantly. A progress note, dated 12/18/23 at 3:24 P.M., indicated the resident stated she had pain and the pain medication she was receiving was "not enough". On 6/4/24 at 8:26 A.M., LPN (Licensed Practical Nurse) 19 indicated that Resident 6 received routine and PRN pain medication as well as a pain patch. The resident did not receive non-pharmacological pain interventions. She further indicated that therapy could provide thermal heat, but the resident would need a referral to therapy to be evaluated for that. On 6/4/24 at 11:04 A.M., the Therapy Supervisor indicated Resident 6 had been seen by therapy from May to June of 2023 where she was evaluated for hot and cold therapy and it was provided. She indicated that once residents are			

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	discharged from the therapy caseload, nurses can come get thermal pads with covers from therapy to use as long as there was a nursing order for it. On 6/4/24 at 11:10 A.M., RN (Registered Nurse) 35 indicated a resident needed a physician order for heat. On 6/5/24 at 9:01 A.M., the ADON (Assistant Director of Nursing) indicated there was no policy for heat use in therapy or as a non-pharmacological pain relief. Heating devices were not allowed in resident rooms because residents could get burned. Staff could use a washcloth heated with faucet water. Otherwise, the resident got referred to therapy. She was unsure how a resident could continue to receive heat as pain relief once discharged from the therapy caseload. She further indicated she would place a referral for Resident 6 to be evaluated by therapy for heat treatment. On 6/4/24 at 10:29 A.M., Medical Records employee provided a current Pain Management policy, dated 11/28/23, that indicated "Non-pharmacological interventions will include but are not limited to...physical modalities (e.g. cold compress, warm shower/bath...)". 3.1-37(a)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours			

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	worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, record review, and interview, the facility failed to ensure accurately completed staff sheets were posted daily for 6 of 7 days during the survey. (5/28, 5/29, 5/30, 5/31, 6/3, 6/4) Findings include: On 5/28/24 at 2:08 P.M., a posted staffing sheet	F 0732	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were affected. 2. All residents have the potential to be affected. 3. The facility Staff Posting policy was reviewed and revised, as was the form for use. It now has an	07/09/2024

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	was observed sitting on a table across from the nurse's station. The sheet included, but was not limited to, the following information: Shift hours for RN (Registered Nurse), LPN (Licensed Practical Nurse) and CNA (Certified Nursing Assistant) Number of RN, LPN, and CNA for each shift Scheduled hours to work of RN, LPN, and CNA for each shift Actual hours worked of RN, LPN, and CNA for each shift. The sheet lacked a designation of actual shift hours worked for the part of the shift for LPN and CNA's 2 P.M. to 10 P.M. On 5/29/24 at 8:10 A.M., a posted staffing sheet was observed sitting on a table across from the nurse's station, The sheet included, but was not limited to, the following information: Shift hours for RN (Registered Nurse), LPN (Licensed Practical Nurse) and CNA (Certified Nursing Assistant). Number of RN, LPN, and CNA for each shift Scheduled hours to work of RN, LPN, and CNA for each shift Actual hours worked of RN, LPN, and CNA for each shift The sheet lacked a designation of actual shift hours worked for the part of the shift for CNA from 2:00 P.M. to 10:00 P.M. On 5/30/24 at 8:00 A.M., a posted staffing sheet was observed sitting on a table across from the nurse's station. The sheet included, but was not limited to, the following information: Shift hours for RN, LPN and CNA Number of RN, LPN, and CNA for each shift Scheduled hours to work of RN, LPN, and CNA for each shift Actual hours worked of RN, LPN, and CNA for		area to indicated if a partial shift is worked what hours that shift is scheduled for. Licensed nursing staff and the nursing scheduler were educated on this new policy and form. The HFA or his designee will audit the staffing posting 3 times weekly for 6 weeks and until 100% compliance is achieved, then one weekly for 6 months and until 100% compliance is maintained to ensure all full and partial shift times are listed. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	each shift The sheet lacked a designation of actual shift hours worked for the part of the shifts worked by RN from 6 A.M. to 2:00 P.M. and RN and CNA's for 2 P.M. to 10 P.M. On 5/31/24 at 8:05 A.M., a posted staffing sheet was observed sitting on a table across from the nurse's station. The sheet included, but was not limited to, the following information: Shift hours for RN, LPN and CNA Number of RN, LPN, and CNA for each shift Scheduled hours to work of RN, LPN, and CNA for each shift Actual hours worked of RN, LPN, and CNA for each shift The sheet lacked a designation of actual shift hours worked for the part of the shifts worked by CNA's from 2 P.M. to 10 P.M. On 6/3/24 at 8:05 A.M., a posted staffing sheet was observed sitting on a table across from the nurse's station. The sheet included, but was not limited to, the following information: Shift hours for RN, LPN and CNA. Number of RN, LPN, and CNA for each shift Scheduled hours to work of RN, LPN, and CNA for each shift Actual hours worked of RN, LPN, and CNA for each shift The sheet lacked a designation of actual shift hours worked for the part of the shifts worked by LPN's from 2 P.M. to 10 P.M. and CNA's 2 P.M. and 10 P.M. On 6/4/24 at 8:30 A.M., a posted staffing sheet was observed sitting on a table across from the nurse's station. The sheet included, but was not limited to, the following information: Shift hours for RN, LPN and CNA.			

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	155803	A. BUILDING 00 B. WING	06/05/2024

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	Number of RN, LPN, and CNA for each shift Scheduled hours to work of RN, LPN, and CNA for each shift Actual hours worked of RN, LPN, and CNA for each shift The sheet lacked a designation of actual shift hours worked for the part of the shifts worked by LPN's on 2 P.M. to 10 P.M. and 6:00 A.M. and 6:00 P.M. and CNA's 2 P.M. and 10 P.M. On 6/4/24 at 1:30 P.M., the DON (Director of Nursing) presented the posted staffing sheets for 5/28, 5/29, 5/30, 5/31, 6/3, and 6/4/24. During an interview on 6/5/24 at 10:55 A.M., the DON indicated they were unaware of the making a designation of the actual hours worked of the half shifts posted on staffing sheets. On 6/5/24 at 11:04 A.M., the DON presented a current policy "Posting Direct Care Daily Staffing Numbers" revised 10/22. The policy indicated " the facility will post on a daily basis prior to each shift, the number of nursing personnel responsible for providing direct care to the resident. The following information will be posted...the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift..."			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to ensure it was free of a	F 0759	The facility will ensure this requirement is met through the	07/09/2024

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	medication error rate of greater than 5 percent (%) for 2 of 3 residents (Resident 6, Resident 17) observed during medication pass. Three medication errors were observed during 25 opportunities for error in medication administration. This resulted in a medication error rate of 12%. Findings include: 1. On 6/3/24 at 6:50 A.M., LPN 19 was observed to administer medications to Resident 17. LPN 19 put two chewable tablets of calcium carbonate 500mg (milligram) into the same medication cup as the other medications, and administered them all to the resident to swallow them. LPN 19 then removed a patch from the resident's back with bare hands, and applied a new patch (rivastigmine 4.6/24) also with bare hands. On 6/5/24 at 10:10 A.M., Resident 17's clinical record was reviewed. Diagnosis included, but were not limited to, dementia. Current physician orders included, but were not limited to: Calcium Carbonate tablet chewable 500mg, give 2 tablets by mouth one time a day, dated 11/3/23. Rivastigmime patch 24 hour 4.6/24, apply 1 patch transdermally one time a day, dated 1/30/24. 2. On 6/3/24 at 11:15 A.M., Licensed Practical Nurse (LPN) 19 was observed to administer an insulin injection for Resident 6. LPN 19 drew up 9U (units) of Admelog, went into the resident's room, and administered the injection into the right side of the abdomen. LPN 19 did not keep the needle in the skin for any length of time. Resident 6's clinical record was reviewed on 6/5/24 at 10:20 A.M. Diagnosis included, but were not		following corrective measures: 1. Residents 6 and 17 were not harmed. LPN 19 was educated on the Medication administration policy and the Insulin administration policy. 2. All residents have the potential to be affected. 3. The policies on Medication administration and Insulin administration were reviewed and no changes were indicated. Licensed nursing staff and QMA's will be educated on these policies. The DON or his designee will observe medication administration 5 times weekly, random staff and residents, for 6 weeks and until 100% compliance is achieved, then 5 times monthly for 6 months and until 100% compliance is maintained. 4. The findings of these observations will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	limited to, diabetes. Current physician orders included, but were not limited to: Admelog injection solution, 8 units subcutaneously before meals for diabetes, dated 3/29/24. Admelog injection solution, inject as per sliding scale, dated 3/29/24. On 6/5/24 at 8:15 A.M., Registered Nurse (RN) 31 indicated insulin should be administered into the skin, waiting a few seconds before pulling the needle out to allow for absorption, and staff should wear gloves when taking off and administering medication patches. She further indicated staff should give chewable tablets separate from other oral pills so the resident can chew them as they should not be swallowed. On 6/4/24 at 2:21 P.M., a current Medication Administration policy, dated 2/1/18, was provided and indicated "Follow the six (6) rights of medication administration ... Right route ... Apply gloves to remove old patch and apply new patch" On 6/4/24 at 2:21 P.M., a current Insulin Administration policy, dated 12/21, was provided and indicated "If using a syringe, keep the needle in the skin for count of five (5) seconds" 3.1-48(c)(1)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that			

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	conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure that food was served at palatable temperatures for 1 of 1 trays tested for temperature. (400 Hall) Finding includes: On 5/29/24 at 8:30 A.M., Resident 40 indicated the food was not hot all the time. On 5/29/24 at 2:40 P.M., Resident 6 indicated the food was cold and didn't taste good. On 5/30/24 at 10:47 A.M., Resident 31 indicated the food was not hot all the time. On 5/31/24 at 2:40 P.M., during a Resident Council meeting which consisted of 15 people, the following statement was made about the food temperatures: the food stayed on trays too long while coming down the halls (making the food cold by the time it reached the resident). On 6/3/24 at 10:44 A.M., Cook 28 checked the temperatures of the lunch food items that were on the holding table ready to be served. On 6/3/24 at 11:10 A.M., kitchen staff started plating the food. On 6/3/24 at 11:56 A.M., the lunch cart was delivered to the 400 hall and left in the hallway. Staff were not notified of its arrival.	F 0804	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed and food was warmed for the residents when requested. 2. All residents have the potential to be affected. A Resident Food Council has been established and monthly meetings start this month. 3. The facility policy Monitoring Food Temperatures was reviewed and no changes were indicated. Dining staff were educated on this policy. The Nutritional Services Manager or her designee will conduct temperature test trays 3 times per week for 6 weeks, random times, and until 100% compliance is achieved, then 1 time per week for 6 months and until 100% compliance is maintained. Additionally, Resident interviews will be conducted 2 times per week for 6 weeks, then 1 time per week for 6 months. 4. The findings of these audits, as well as minutes from the Resident Food council, will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	07/09/2024

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	On 6/3/24 at 12:01 P.M., staff started distributing meals to rooms on the 400 hall. On 6/3/24 at 12:12 P.M., a test tray was obtained. Food temperatures for that meal were: carrots 116 F The food tasted lukewarm. On 6/3/24 at 12:24 P.M., the Dietary Manager indicated food should be between 120 to 135 F when served to residents. On 6/4/24 at 10:29 A.M., Medical Records provided a current Food Temperature Monitoring policy, revised 12/22, that indicated "All hot food items must be ... served at a temperature of at least 135 degrees F ... Recommended temperatures on the serving line are higher for hot food and colder for cold food to allow for some changes during meal delivery and service time". 3.1-21(a)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility			

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	gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to store and prepare food under sanitary conditions during 3 of 3 kitchen observations. Food was left open to air, expired food was not disposed of from the refrigerator, and gloves were not used according to professional standards. (Kitchen, Main Dining Room, Cook 21) Findings include: 1. On 5/28/24 at 8:15 A.M., the full kitchen tour with the Dietary Manager indicated the following: In the reach-in freezer, the following items were observed: Slice of orange melon open to air in a tray not labeled or dated 5 small ice cream containers tipped over with the lids half on and half off In the walk-in freezer, the following items were observed: 3 french fries were scattered on the shelves open to air 1 bag of mixed vegetables open to air In the walk-in refrigerator, the following items were observed: 1 broken egg in an egg crate with whole eggs	F 0812	The facility will ensure compliance through the following corrective measures: 1. No residents were affected. All items identified were corrected prior to survey ending. 2. All residents have the potential to be affected. 3. The policies on Food Safety Requirements and Date Marking for Food Safety were reviewed and no changes were indicated. Dietary staff were educated on these policies. The Nutrition Services Manager or her designee will audit kitchen refrigerators/freezers and dining room refrigerator/freezers 3 times per week for 6 weeks and until 100% compliance is achieved, then weekly for 6 months and until 100% compliance is maintained ensuring items are covered and disposed of if expired. She will also observe at least 3 meal preparations weekly to ensure gloves are changed/hand washing occurs when indicated for 6 weeks	07/09/2024

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	Rice with a use by date of Sunday 5/25/24 1 boiled egg on the floor Bag of grapes open to air with no label or date Container of boiled eggs in liquid open to air Cup of juice on the floor 4 small ice cream containers tipped over and melted in nectar orange bin In the dry pantry, the following items were observed: 8 packets of sugar, salt, and pepper on the floor On 6/3/24 at 10:41 A.M., the following items were observed in the walk-in refrigerator: bacon on the floor standing water by the shelves holding bins containing thickened liquids 2. On 5/28/24 at 8:15 A.M., the following items were observed in the holding refrigerator in the main dining room: 2 chocolate milk containers with a use by date of 5/27 2 fat free milk containers with a use by date of 5/27 1 whole milk container with no use by date 3. On 5/30/24 at 10:02 A.M., Cook 21 was observed preparing pureed chicken. Cook 21 put on gloves, cleaned the preparation area, lifted the garbage lid, threw trash in the garage can, replaced the lid, and without changing gloves picked up the cooked chicken and placed it in the blender. On 5/28/24 at 8:15 A.M., the Dietary Manager indicated staff cleaned out the refrigerator daily. She removed the expired items from the refrigerator. On 6/4/24 at 10:29 A.M., Medical Records		and until 100% compliance is achieved, then 5 per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	employee provided a current Leftovers policy, revised 2/20, that indicated "All food stored for later use shall be covered, labeled with the food name, and dated with the current date as well as a "use by" date, then stored appropriately (refrigerated or frozen if necessary) immediately ... Leftovers that have not been properly stored will be discarded...". On 6/4/24 at 10:29 A.M., Medical Records employee provided a current Glove Usage With Food Contact policy, revised 6/21, that indicated "Gloves are just like hands. They are considered a food contact surface that can get contaminated or soiled. Anytime a contaminated surface is touched, the gloves must be changed...". 3.1-21(i)(2) 3.1-21(i)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and			

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

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	(ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on observation, interview and record review, the facility failed to ensure accurate documentation for 1 of 1 residents observed for a glucometer reading, and 1 of 3 residents reviewed for falls. A blood glucose was documented incorrectly, and post-fall assessments were not completed following a fall. (Resident 6, Resident 86) Findings include: 1. On 6/3/24 at 11:15 A.M., Licensed Practical Nurse (LPN) 19 was observed to perform a glucose reading on Resident 6. LPN 19 performed a fingerstick, and obtained a reading of 177. On 6/3/24 at 2:00 P.M., a blood sugar summary for Resident 6 was provided and indicated a blood sugar of 175 on 6/3/24 at 11:20 A.M. On 6/4/24 at 9:15 A.M., Registered Nurse (RN) 31 indicated blood sugar readings should be documented accurately. 2. On 5/30/24 at 2:59 P.M., Resident 86's clinical record was reviewed. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following a cerebral infarction affecting right dominant side, aphasia following cerebral infarction, and muscle weakness.	F 0842	The facility will ensure this requirement is met through the following corrective measures: 1. Residents 6 and 86 were not harmed. 2. All residents have the potential to be affected. 3. The policies related to Documentation in the Medical Record and Fall Investigation and Risk Assessment were reviewed and no changes were indicated. Licensed staff and QMA's will be educated on the Documentation policy and nurses will be educated on the Fall policy. The DON or his designee will complete audits of post-fall assessments 5 days weekly to ensure they are completed for 6 weeks and until 100% compliance is achieved, then twice weekly for 6 months and until 100% compliance is maintained. The DON or his designee will observe medication administration, to include blood glucose testing & documentation, 5 times weekly, random staff and residents, for 6 weeks and until 100% compliance is achieved,	07/09/2024

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	The current admitting MDS (Minimum Data Set) Assessment, dated 2/24/24, indicated the resident was mildly cognitively impaired, was dependent on transferring, dressing and toileting, and had no history of falls. Physician orders included but were not limited to nursing to assist with meals (opening items, set-up, cutting foods, placing silverware, etc.) before meals dated 3/7/24. The current care plan dated 2/23/24 indicated the resident needed assistance with ADL (Activities of Daily Living) related to right sided hemiparesis interventions included, but were not limited to, requiring the assistance of 2 with transfers, pivot transfer toward left side, and use gait belt and grip socks. Re-educate staff to always transfer residents toward left side. Progress note reviewed from 5/7/24 indicated Resident 86 had a fall in the shower. The Post-Fall Assessment started on 5/7/24 that was started on 8:00 A.M. indicated there was no charting at all on 5/7/24, no charting on 5/8 for second and third shifts, one missed assessment on second shift for 5/9. During an interview on 6/5/24 at 10:31 A.M., the Regional Nurse Consultant indicated all blanks should be filled on the fall assessment sheet. On 6/4/24 at 2:21 P.M., the Regional Nurse Consultant presented a current policy "Documentation in Medical Record" dated 1/30/23. The policy indicated " each resident's medical record shall contain an accurate representation of the actual experiences and include enough information to provide a picture of the resident's progress through complete,		then 5 times monthly for 6 months and until 100% compliance is maintained. 4. The findings of these audits/observations will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	accurate, and timely documentation...Documentation shall be accurate, relevant, and complete...will be timely and in chronological order." 3.1-50(a)(2)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other			

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HAMILTON POINTE HEALTH AND REHAB	3800 ELI PLACE NEWBURGH, IN 47630

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	persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 0880	The facility will ensure this	07/09/2024

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	Based on observation, interview, and record review, the facility failed to ensure a safe, sanitary, and comfortable environment to help prevent the development and transmission of infection for 6 of 6 random observations. Resident care items were observed uncovered in bathrooms, and staff did not sanitize hands entering or exiting rooms with enhanced barrier precautions as indicated. (Resident 37, Resident D, Resident 7, Resident 46, Resident 20) Findings include: 1. On 5/30/24 at 9:38 A.M., Resident 7's bathroom was observed with four uncovered washbasins on the floor. On 6/5/24 at 8:30 A.M., the same was observed. 2. On 5/30/24 at 9:14 A.M., Resident 46's bathroom was observed with an uncovered washbasin in the sink. 3. On 5/30/24 at 10:10 A.M., Resident 20's bathroom was observed with an uncovered toothbrush on the back of the sink. On 6/5/24 at 8:29 A.M., the same was observed. 4. On 6/3/24 at 7:16 A.M., Qualified Medication Aide (QMA) 23 was observed to attempt to administer medications to Resident 37. QMA 23 entered and exited Resident 37's room without sanitizing or washing her hands. At that time, a sign was observed attached to the door that indicated enhanced barrier precautions, and that everyone must clean their hands, including before entering and when leaving the room. 5. On 6/3/24 at 7:26 A.M., QMA 23 was observed		requirement is met through the following corrective measures: 1. Residents 7, 46, and 20's personal hygiene items were removes from the bathroom/bagged. QMA 23 was educated on hand hygiene/EBP's. 2. All residents have the potential to be affected. Rounds were made throughout the building and personal hygiene items were removed/bagged from bathrooms. 3. The policy on Enhanced Barrier Precautions was reviewed and no changes were indicated. Nursing staff will be educated on this policy and personal items storage. The IP or her designee will make rounds/ observations 5 times weekly, varying shifts, for 6 weeks and until 100% compliance is achieved, then weekly for 6 months and until 100% compliance is achieved to ensure personal hygiene products are stored appropriately and that hand hygiene is observed before entering and upon exiting a room on any sort of isolation. The IP or her designee will make rounds/observations to ensure resident personal hygiene products are not left uncovered in bathrooms of 10 resident rooms twice weekly for six weeks and until 100% compliance is achieved, then 10 per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits will	

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	to enter Resident D's room with a blood pressure machine. QMA entered and exited the room without sanitizing or washing her hands. QMA 23 was observed to immediately enter the room a second time without performing hand hygiene. At that time, a sign was observed attached to the door that indicated enhanced barrier precautions, and that everyone must clean their hands, including before entering and when leaving the room. On 6/5/24 at 8:15 A.M., Registered Nurse (RN) 31 indicated when entering rooms on enhanced barrier precautions, staff should sanitize hands before entering and when leaving even if not providing direct contact with the resident. On 6/5/24 at 8:37 A.M., Certified Nurse Aide (CNA) 77 indicated the toothbrush in Resident 20's bathroom was uncovered because the staff were not provided with anything to cover them with. He indicated washbasins should be covered and not sitting directly on the floor. On 6/5/24 at 11:25 A.M., a current Enhanced Barrier Precautions policy, dated 3/26/24, indicated "It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms" 3.1-18(b) 3.1-18(j) 3.1-18(l)		be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	
F 0925 SS=E Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.			

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	Based on observation, record review, and interview, the facility failed to provide an environment free of pests based on 8 (eight) random observations of gnats during the survey. (800 Nursing Hall, Kitchen, 300 Nursing Hall, Nurses Station, Dining Room, Resident Room 809, ADON (Assist Director of Nursing) Office, and Nursing Manger Office) Findings include: 1. On 5/29/24 at 3:05 P.M., during a random observation a gnat was observed flying in a resident's room. 2. On 5/31/24 at 10:05 A.M. during a random observation gnats were observed flying in a Nursing Manager Office. 3. On 6/3/24 at 10:27 A.M., during a random observation in the ADON's office, several gnats were observed flying about in the room. 4. On 5/29/24 at 9:16 A.M., Resident 84 indicated she had a problem with gnats in her room. At that time, gnats were observed in her room. 5. On 5/29/24 at 2:39 P.M., gnats were observed in Resident 6's room. 6. On 6/3/24 at 11:32 A.M., gnats were observed in the main dining room. 7. On 6/3/24 at 11:53 A.M., eight gnats were observed on the window of the 300 hall nurse station. 8. On 6/3/24 at 10:41 A.M., gnats were observed in the dry pantry in the kitchen. During an interview on 6/3/24 at 10:27 A.M., the	F 0925	The facility will ensure this requirement is met though the following corrective measures: 1. No residents were harmed. Pest Control was contacted and a visit requested to treat for gnats. 2. All residents have the potential to be affected. Pest Control treatments are in progress. 3. The Pest Control policy was reviewed and no changes were indicated. The maintenance staff will be educated on this policy. The Maintenance Director or his designee will conduct rounds twice weekly for six weeks, then weekly thereafter to ensure gnats are identified and treatment completed when found. 4. The findings of these rounds will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	07/09/2024

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	ADON indicated over the weekend the fire department was at the facility over the weekend and flushed some pipes and thinks that the gnats were stirred up at this time. During an interview on 6/05/24 at 9:37 A.M., the DON (Director of Nursing) indicated they would not expect the facility to have pests. On 6/5/24 at 10:15 A.M., the Administrator provided a current policy "Pest Control" dated 3/7/23. The policy indicated "...it is the policy of the facility to provide a safe...environment of care...maintain an effective pest control program...free of pest..." 3.1-19(f)(4)			
F 9999 Bldg. 00	3.1-28 STAFF TREATMENT OF RESIDENT (c) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including to the state survey and certification agency. This State Rule is not met as evidenced by: Based on record review and interview, the facility failed to report an injury of unknown source to the Indiana Department of Health (IDOH) for 1 of 1 resident reviewed for injuries of unknown source. (Resident D)	F 9999	The facility will ensure this requirement is met through the following corrective measures 1. No residents were affected by the lack of reporting. 2. All residents have the potential to be affected. 3. The policy IDOH-LTC Abuse & Incident Reporting Policy was reviewed and has not been revised. Facility leadership was provided education regarding the reporting of injuries of unknown origin. The DON or his designee will review all noted injuries to ensure an investigation has been conducted and the incident reported, if indicated, 5 times weekly on-going.	07/09/2024

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	Finding includes: On 5/30/24 at 1:21 P.M., Resident D's clinical record was reviewed. Diagnoses included, but were not limited to, displaced fracture of the medial condyle of left tibia, wedge compression fracture of fourth thoracic vertebra, and dementia. The current Quarterly MDS (Minimum Data Set) Assessment dated 5/10/24 indicated Resident D was mildly cognitively impaired and had a history of falls. Resident D is dependent for assistance with mobility and transfer. During record review, an X-Ray of the resident's left femur and lower leg was conducted on 5/9/24 at (Name of Hospital) indicated there was an acute fracture of the proximal tibia. A second X-Ray of left knee on 5/23/24 conducted at (Office) indicated there was no change in the displacement and had some healing. The record lacked notification of an injury of unknown source. During an interview on 6/3/24 at 2:10 P.M., the Administrator indicated that everything from the hospital says the age of fracture was age undetermined, was not acute so it was not reported. On 6/3/24 at 2:00 P.M., the Regional Nurse Consultant provided a current policy "Administrative-Accidents and Incidents Investigating and Reporting" revised in 7/21. The policy indicated "to ensure the reportable occurrences are recorded and monitored to facilitate compliance with the state and federal laws. Unusual occurrences reported to the Indiana State Department of Health will be recorded,		4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	tracked, and monitored to ensure residents are receiving appropriate care and services....Injury of an unknown source should be classified and as an injury of unknown source when both of the following conditions are met: the source of the injury was not observed, and the injury is suspicious because of the extent of the injury or the location..." This citation relates to complaint IN00435563.			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00435563. Survey dates: May 28, 29, 30, 31, June 3, 4, 5, 2024. Facility number: 012966 Residential Census: 53 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions,			

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	except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to conduct fire and disaster drills every 6 (six) months in conjunction with the local fire department. Finding includes: During a review of the fire drill reports for June 2023-June 2024, on 5/31/24 at 10:30 A.M., the reports indicated fire drills were conducted every month. The fire drill reports had not indicated that the local fire department had been contacted to participate in a fire drill. During an interview with the Administrator on 5/31/24 at 2:30 P.M., he indicated the facility does not technically have an invitation to the fire marshal showing they were invited to participate every 6 (six) months in a drill. During a review of the facility's current fire drill policy provided on 5/31/24 at 2:30 P.M., it indicated all, or in part, but not limited to...fire drill	R 0092	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were affected. 2. All residents have the potential to be affected. 3. The policy was reviewed and no changes were indicated. The Maintenance staff will be educated on this policy. The HFA or his designee will monitor monthly to ensure that the fire department is invited to participate in fire and disaster drills at least every six months and that documentation of proof of such invitations is retained for the facility records. These audits will continue monthly for 6 months and until 100% compliance is achieved, then quarterly for 12 months and until 100% compliance is maintained. 4. The findings of these audits will	07/09/2024

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	frequency is based on code requirement in NFPA 101 and Indiana State Life Safety.		be presented during the facility's monthly QAPI meetings and the plan of action revised accordingly.	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance (h) The facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education, if applicable. (5) Professional licensure or registration number or dining assistant certificate or letter of completion, if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility, including residents' rights, and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with facility policy. (10) Date and reason for separation. Based on record review and interview, the facility failed to ensure QMAs (Qualified Medication Aide) had a current and valid license to work in the facility for 1 of 13 QMAs reviewed for licensure. (QMA 4) Finding includes: On 6/5/24 at 8:12 A.M. employee records reviewed. QMA 4's license expired on 12/12/23. She was hired on 4/30/24. On 6/5/24 at 1:34 P.M., the Administrator provided	R 0123	1. No residents were harmed. QMA 4 was removed from the schedule until required inservicing completed and certification renewed. 2. All residents have the potential to be affected. Licenses and certifications of staff were audited to ensure all were up to date. 3. The regulation is the facility's guide. HR staff will be re-educated on this regulatory requirement. The HR Director of	07/09/2024

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	shifts QMA 4 worked since her hire date. QMA 4 worked as a QMA five shifts since 4/30/24. At that time, the Administrator indicated QMA most likely passed medications during her shift and only worked on the residential side of the building. Human Resources (HR) was responsible for making sure licensure was kept current and was aware that QMA 4's license was expired. It had not been renewed yet because QMA 4 had not completed the Continuing Education (CE) inservices required to renew the license. He further indicated it was the facility's policy to ensure staff had current and valid licenses.		his designee will complete an audit of 5 random AL staff members who require a license/certification weekly for 6 weeks and until 100% compliance is achieved to ensure licenses/certifications are in good standing. Then he/she will complete a monthly audit on 10 random AL staff for 6 months and until 100% compliance is maintained to ensure the same. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to ensure medications were given as ordered by the physician for 2 of 7 residents reviewed for medication administration. (Resident 264, Resident 278) Findings include: 1. On 5/30/24 at 10:15 A.M., Resident 264's clinical record was reviewed. Current physician orders included, but were not limited to:	R 0241	The facility will ensure this requirement is met through the following corrective measures: 1. Residents 264 & 278 were not harmed. The physician was notified of the medication given outside of parameters. 2. All residents with administration parameters have the potential to be affected. The last 30 days of EMAR's will be reviewed and notifications made	07/09/2024

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	metoprolol succinate ER (extended release) (blood pressure medication) oral tablet extended release 24 hour 50 mg (milligram) give 50 mg by mouth one time a day for heart rate. Hold for HR (heart rate) <60 or SBP (systolic blood pressure) <110, order date 8/16/23. The EMAR (electronic medication administration record) was reviewed for February, March, April, May 2024 and the medication was not given as ordered on the following dates: 2/3- b/p (blood pressure) 113/56 2/17- b/p 140/59 3/17- b/p 148/58 4/28- b/p 127/57 5/1-b/p 132/56 5/2- b/p 112/54 5/4- b/p 133/59 5/8- b/p 133/52 5/16- b/p 128/58 5/26- b/p 122/52 2. On 5/30/24 at 11:30 A.M., Resident 278's clinical record was reviewed. Current physician orders included, but were not limited to: Cardizem CD (controlled delivery) (blood pressure medication) oral capsule extended release 24 hour 120 mg give one capsule by mouth one time a day for cardiac related to essential (primary) hypertension. Hold if (sic) systolic is less than 120 or diastolic is less than 80. order date 6/8/23. Hold Cardizem if systolic is less than 120 or diastolic is less than 80 every day shift, start date 6/8/23. The EMAR (electronic medication administration record) was reviewed for February, March, April,		as indicated. 3. The policy on Medication Administration was reviewed and no changes were indicated. Licensed nurses and QMA's will be re-educated on this policy. The unit manager or his designee will complete EMAR reviews twice weekly to ensure administration parameters are followed for 6 weeks and until 100% compliance is achieved, then every 2 weeks and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	May 2024 and the medication was not given as ordered on the following dates: 2/5- b/p 126/61 2/12- b/p 136/67 3/9- b/p 140/72 4/6- b/p 148/75 4/12- b/p 134/58 4/14- b/p 137/67 4/18- b/p 164/72 4/20- b/p 140/64 4/22- b/p 140/58 4/27- b/p 121/63 4/29- b/p 138/68 5/1-b/p 130/70 5/6- b/p 150/72 5/13- b/p 146/72 5/22- b/p 158/78 On 6/4/24 at 1:46 P.M., the DON indicated if vital signs fall outside of parameters, staff should hold medication. The order will state what parameters to hold medications, if outside of parameters three days or longer, notify nurse practitioner or physician. On 5/31/24 at 1:10 P.M., the Administrator provided the current policy on medication administration with a revision date of February 2023. The policy included, but was not limited to: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection...			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas			

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	155803	A. BUILDING 00 B. WING	06/05/2024

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	(excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to store and prepare food under sanitary conditions during 3 of 3 kitchen observations. Food was left open to air, expired food was not disposed of from the refrigerator, and gloves were not used according to professional standards. (Kitchen, Main Dining Room, Cook 21) Findings include: 1. On 5/28/24 at 8:15 A.M., the full kitchen tour with the Dietary Manager indicated the following: In the reach-in freezer, the following items were observed: Slice of orange melon open to air in a tray not labeled or dated 5 small ice cream containers tipped over with the lids half on and half off In the walk-in freezer, the following items were observed: 3 french fries were scattered on the shelves open to air 1 bag of mixed vegetables open to air In the walk-in refrigerator, the following items were observed: 1 broken egg in an egg crate with whole eggs Rice with a use by date of Sunday 5/25/24 1 boiled egg on the floor Bag of grapes open to air with no label or date Container of boiled eggs in liquid open to air Cup of juice on the floor 4 small ice cream containers tipped over and	R 0273	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were affected. All items identified were corrected prior to survey ending. 2. All residents have the potential to be affected. 3. The policies on Food Safety Requirements and Date Marking for Food Safety were reviewed and no changes were indicated. Dietary staff were educated on these policies. The Nutrition Services Manager or her designee will audit kitchen refrigerators/freezers and dining room refrigerator/freezers 3 times per week for 6 weeks and until 100% compliance is achieved, then weekly for 6 months and until 100% compliance is maintained ensuring items are covered and disposed of if expired. She will also observe at least 3 meal preparations weekly to ensure gloves are changed/hand washing occurs when indicated for 6 weeks and until 100% compliance is achieved, then 5 per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted	07/09/2024

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	melted in nectar orange bin In the dry pantry, the following items were observed: 8 packets of sugar, salt, and pepper on the floor On 6/3/24 at 10:41 A.M., the following items were observed in the walk-in refrigerator: bacon on the floor standing water by the shelves holding bins containing thickened liquids 2. On 5/28/24 at 8:15 A.M., the following items were observed in the holding refrigerator in the main dining room: 2 chocolate milk containers with a use by date of 5/27 2 fat free milk containers with a use by date of 5/27 1 whole milk container with no use by date 3. On 5/30/24 at 10:02 A.M., Cook 21 was observed preparing pureed chicken. Cook 21 put on gloves, cleaned the preparation area, lifted the garbage lid, threw trash in the garage can, replaced the lid, and without changing gloves picked up the cooked chicken and placed it in the blender. On 5/28/24 at 8:15 A.M., the Dietary Manager indicated staff cleaned out the refrigerator daily. She removed the expired items from the refrigerator. On 6/4/24 at 10:29 A.M., Medical Records employee provided a current Leftovers policy, revised 2/20, that indicated "All food stored for later use shall be covered, labeled with the food name, and dated with the current date as well as a "use by" date, then stored appropriately (refrigerated or frozen if necessary) immediately ...		accordingly.	

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	Leftovers that have not been properly stored will be discarded...". On 6/4/24 at 10:29 A.M., Medical Records employee provided a current Glove Usage With Food Contact policy, revised 6/21, that indicated "Gloves are just like hands. They are considered a food contact surface that can get contaminated or soiled. Anytime a contaminated surface is touched, the gloves must be changed...".			
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation, and interview, the facility failed to ensure medications were labeled correctly and had open dates for 3 of 4 observations of medication carts.(Resident 261, Resident 262, Resident 268, Resident 269, Resident 294, Resident 295, Resident 280, Resident 301, Resident 303, Resident 307, Resident 313, dementia unit medication cart, 100 unit medication cart, 200 unit medication cart) Findings included: 1. On 5/30/24 at 8:45 A.M., the medication cart on the locked dementia unit was observed to have the following medications and supplements improperly tabled. None had a physician's name. Resident 294: equate pain reliever 500 mg (milligram) -name only	R 0302	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. All OTC medication were labeled and re-ordered as indicated. 2. All residents have the potential to be affected. 3. The policy Labeling Medications and Biologicals was reviewed and no changes were indicated. Licensed nurses and QMA's will be educated on this policy. The AL Unit Manager will complete weekly audits of the medication carts to ensure that medications are dated and labeled appropriately for 6 weeks and until 100% compliance is achieved, then monthly for 6 months and	07/09/2024

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	Resident 295: aspirin 81 mg - name only preservision mini soft gels fareds 2 formula - name only Resident 301: fluticasone propionate 50 mcg (microgram) nasal spray - no open date Resident 303: 220 zinc 220 mcg - name only vitamin B12 1000 mcg -name only vitamin D3 2000 IU (international unit) 50 mcg -name only complete vitamin- initials only Colace 100 mg laxitive - name only melatonin 5 mg supplement - name only Resident 307: ventolin hfa 90 mcg inhaler - no open date Resident 313: equate pain reliever 325 acetaminophen - name only No resident identifier : vitamin E 500 mg 2 bottles of vitamin D3 2000 IU melatonin 5 mg advil 20 mg liquid gels vitamin B12 1000 mcg vit c 500 mg with rose hips one a day mens 50 plus vitamin two bottles of Bayer aspirin 81 mg First name only : Tylenol 500 mg probiotic 100 million organisms one a day womens 50 plus vitamin vitamin D3 5000 IU 2. On 5/29/24 at 9:10 A.M. the 100 unit medication cart was observed to have the following, none had a physician's name.		until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	Resident 261: refresh tears lubricant eye drops - no open date Resident 262- timolol maleate 0.5 % eye drop - no open date earwax remover drops carbamide peroxide 6.5 % - no resident identifier Resident 268: citracal plus D3- name only 3. On 5/29/24 at 9:19 A.M., the west unit cart was observed to have the following : Resident 269: fluticasone propionate 50 mcg nasal spray- no open date Resident 280: 2 bottles of dorzolamide hydrochloride and timolol eye drop 22.3 mg/6.8 mg -no open date On 5/29/24 at 9:12 A.M., QMA 1 indicated the staff opening the eye drop is supposed to put the date and time opened, and their initials. On 5/29/24 at 9:50 A.M., LPN 1 indicated an open date and expiration date is supposed to be written on the medication bottle when it is opened. On 5/31/24 at 1:10 P.M., the Administrator provided the current policy on labeling medications and biologicals with a revision date of February 2023. The policy included, but was not limited to: All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications...			