STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VILLAS OF GUERIN WOODS	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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 and the Investigation of Complaint IN00406320. Complaint IN00406320 - No deficiencies related to the allegations are cited. Survey dates: April 19, 20, 21, 24, 25, and 26, 2023. Facility number: 011509 Provider number: 155770 AIM number: 200909280 Census Bed Type: SNF/NF: 65 Residential: 9 Total: 74 Census Payor Type: Medicare: 10 Medicaid: 37 Other: 18 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 1, 2023.	F 0000	**Plan of Correction for the Villas of Guerin Woods from the April 26, 2023, Recertification and State Licensure with State Residential Licensure and Complaint Survey** The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric Will	Administrator	05/18/2023

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

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	when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical			

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	configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to notify the physician when a resident developed a firm to the touch raised area in a recent surgical incision of a hip fracture for 1 of 6 residents reviewed for physician notification. (Resident 17) Finding includes: The record for Resident 17 was reviewed on 4/24/23 at 9:53 a.m. The diagnoses included, but were not limited to, displaced intertrochanteric fracture of left femur, fracture of the left upper end of left tibia, muscle weakness, age-related osteoporosis, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 3/24/23, indicated the resident was severely cognitively impaired, required extensive assistance of two staff members' for bed mobility and transfers, required one staff member's assistance to ambulate in room, her balance was unsteady which required staff to help stabilize, she had one fall since her admission, and she had one side lower extremity impairment in functional range of motion. On 2/7/23, the physician gave an order for the resident to be non-weight bearing on the left leg. A Weekly Skin Assessment, dated 4/22/23, indicated the resident's left hip to mid thigh incision had redness at the site of the staples and an area mid staple with firmness.	F 0580	**F 0580** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. The physician for resident #17 was notified of a raised area that is firm to the touch in the incision from a recent medical procedure. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. Residents with a surgical incision were assessed and if a change in condition was identified, their physician was notified. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. Licensed Nursing staff were re-educated on the facilities	06/01/2023

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	A Skin/Wound Note, dated 4/22/23, indicated the resident's left hip had serosanguinous and bloody drainage from the upper staples site with golf ball sized firmness. The clinical record lacked documentation of the physician having been notified of the change in the surgical incision site. During an interview on 4/24/23 at 10:10 a.m., the Unit Manager indicated that if the nurse noticed an area on a surgical incision that was golf ball size with firmness, the Nurse Practitioner or Physician should have been immediately notified for new orders. On 4/24/23 at 1:10 p.m., the Unit Manager presented a copy of the facility's current policy titled "Change in a Resident's Condition or Status" dated 12/16/21. The policy included, but was not limited to, "... Policy Statement: Our facility shall promptly notify the resident, his or her Attending Physician... of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care... Policy Interpretation and Implementation: 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an)... d. significant change in the resident's physical... condition... i. specific instruction to notify the Physician of changes in the resident's condition... 4. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical... condition or status..." 3.1-5(i)(B) 3.1-5(i)(C)		"Change in the resident's condition or status" policy and Physician notification. 2. All resident progress notes will be reviewed during daily clinical review to ensure the physician was notified with any change of condition. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. The DON/designee will audit all resident progress notes daily to ensure there is documentation on Physician notification for any change of condition. 2. A Performance Improvement Tool has been initiated to ensure there is Physician notification for any resident change in condition. The DON/designee will complete this audit daily x 6 months. Any issues identified will be immediately corrected. The QA committee will review the tool at regularly scheduled meetings and make additional recommendations as needed based on the outcome of the tool. The review of the tool as indicated above will increase to daily monitoring if less than 100%. The Quality Assurance Committee will continue to review the auditing tool until the tool shows 100%	

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			compliance, at which time the committee may decrease the monitoring increments. Non-compliance by an employee will result in additional education or corrective action up to and including termination. **5.** Competition date: 6/1/2023	
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review and interview, the facility failed to ensure an ongoing activity program to meet the interest of and support the physical, mental, and psychosocial well-being of the residents for 6 of 6 resident observations. This deficient practice had the potential to affect all 65 residents residing in the facility. (Residents 24, 28, 35, 47, 50, and 45) Findings include: 1. The record for Resident 24 was reviewed on 4/24/23 at 10:08 a.m. The diagnoses included but were not limited to dementia, anxiety disorder, and	F 0679	**F 0679** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Residents 24, 28, 35,47,50 & 45 have been interviewed regarding activity preferences and activities have been initiated and an ongoing activity program to meet the interest of and support the physical, mental, and psychosocial well-being.	06/01/2023

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	major depressive disorder. The Quarterly MDS (Minimal Data Set) assessment, dated 3/8/23, indicated the resident was moderately intact cognitively. The care plan, dated 12/21/21 and revised on 8/19/22, indicated Resident 24 would actively participate in activities of interest, his family visited a lot, he enjoyed playing games with the group and watched his television daily, he enjoyed coloring and the activity department would supply coloring pages and colored pencils as needed. The resident enjoyed listening to music. The activity department would provide a monthly activities calendar and staff would assist the resident to activities as warranted. The Activity Note, dated 3/8/23 at 8:35 a.m., indicated the resident had a diagnosis of dementia, and a cognitive communication deficit. He was up and attended all meals in the social dining room. He liked to watch television and listen to music in his room. The resident liked receiving the daily paper to read. He participated in activities of his interest. The resident's family visited daily and saw to all his needs. He was very hard of hearing, and he read his Bible in his room, painted, and attended bingo. During an observation, on 4/19/23 at 9:30 a.m., Villa 3 had three residents sitting in the dining room. Two residents were sleeping, and 1 resident was sitting at the table. No activities were observed. During a tour of the unit no activities were observed with the residents in their rooms. During an interview on 4/19/23 at 1:12 p.m., Resident 24 indicated the only activity the facility did was bingo and he got tired of bingo.		2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All residents have the potential to be affected by this practice. 2. All residents have been interviewed to ensure activity preferences are being met. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. The Activity Director was educated on honoring activity preferences and ensuring programs are ongoing to meet the resident interest. 2. All nursing staff have been educated on ensuring activity programs are offered to the residents to meet their interest. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. The Activity Director/designee will audit the	

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	During an observation, on 4/20/23 at 1:30 p.m., there were no activities being conducted in Villas 2 and 4. During an observation, on 4/21/23 at 10:00 a.m., there were no activities being conducted. The residents were in their rooms. During an observation, on 4/21/23 at 10:15 a.m., Villa 2 had 3 residents in the dining/TV area. One resident had a visitor, and 2 residents were asleep. No activities were being conducted with the residents in their rooms. During an interview on 4/21/23 at 10:20 a.m., LPN (Licensed Practical Nurse) 15 indicated staff did not have time to do a lot of activities with the residents. That put a lot on the staff. The residents could go to another villa for an activity, but staff would need to take them and bring them back. Staff would do exercises with the resident while providing care. The staff or residents did not know what time an activity started. The activity calendar did not have any times for when the activity started. Staff could not get activities done like they wanted to. During an interview on 4/21/23 at 10:30 a.m., QMA (Qualified Medication Aide) 17 indicated she did not know what the activities were. There was a box that the residents could pick a craft from and do it themselves. If visitors or other people were in the building, staff could do more activities with the residents. 2. The record for Resident 28 was reviewed on 4/21/23 at 10:39 a.m. The diagnoses included, but were not limited to, depressive episodes and anxiety disorder.		Activity attendance records and monitor activity programs to ensure residents are offered Activities of their preference. 2. A Performance Improvement Tool has been initiated to ensure residents are receiving Activities of preference. The ED/designee will complete this audit 5 days a week x 4 weeks then weekly x 5 months. Any issues identified will be immediately corrected. The QA committee will review the tool at regularly scheduled meetings and make additional recommendations as needed based on the outcome of the tool. The review of the tool as indicated above will increase to daily monitoring if less than 100%. The Quality Assurance Committee will continue to review the auditing tool until the tool shows 100% compliance, at which time the committee may decrease the monitoring increments. e DON/designee will review any findings daily. Non-compliance by an employee will result in additional education or corrective action up to and including termination. 5. Competition date: 6/1/23	

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	The Activity Admission Assessment, dated 12/28/22, indicated the resident desired to participate in religious or spiritual activities. It was very important to her to have books, newspapers, and magazines to read, to listen to music she liked, to keep up with the news, to do things with groups of people, to do her favorite activities, to go outside to get fresh air when the weather was good, and to participate in religious services or practices. The Admission MDS assessment, dated 1/4/23, indicated the resident was alert and oriented but required cues for temporal orientation, had no mood or behavior issues or impairment in functional range of motion, required supervision for transfers and ambulation. It was very important to her to have books, newspapers, and magazines to read, to listen to music she liked, to do things with a group of people, to do favorite activities, to go outside weather permitting, and to participate in religious services. The activity care plan, dated 1/9/23, indicated the resident was active in activities and enjoyed games, beauty shop, nails, puzzles, and talking with others. Activities would remind her to attend groups. The goal for the resident was to attend groups weekly and/or daily. The approaches were to provide a calendar, invite to groups, and provide leisure materials. The Quarterly MDS assessment, dated 4/2/23, indicated the resident's cognitive status had improved since admission. During an observation of Villa 5, on 4/19/23 at 9:45 a.m., the resident was observed to be playing solitaire by herself near the courtyard. At that time, the resident indicated she was playing cards			

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	as she was one who liked to keep busy as much as possible and there wasn't really anything else going on. During an observation of Villa 5, on 4/20/23 at 10:15 a.m., the resident was sitting by herself in a chair near the courtyard. No activities were occurring, nor was the resident provided with something to do. During an observation of Villa 5 on 4/21/23 at 10:10 a.m., the resident was observed playing solitaire near the courtyard. She indicated there was not much going on that she was aware of. She thought they passed out a calendar monthly but didn't know where it was. During an interview with LPN 18 on 4/21/23 at 10:20 a.m., she indicated that usually activities were occurring every afternoon in each of the Villas. The activities in the villas depended on the cognitive level of the residents in the Villa. Cards, bingo, card bingo, and nails were the usual activities. 3. The record for Resident 35 was reviewed on 4/25/23 at 8:14 a.m. The diagnosis included, but was not limited to, depression. The care plan, initiated on 8/17/22, indicated the resident enjoyed watching his TV and receiving the newspaper. He liked word search books and had several in his room. He had a cell phone and an iPad he used daily. He had mentioned that he would be interested in the Library Club so activities would set that up. Activities would provide leisure materials as needed and encourage group participation. The interventions included, but were not limited to, provide newspaper, library books, and word search books, provide a monthly calendar, encourage the resident to participate in			

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	group activities. The Quarterly MDS assessment, dated 2/23/23, indicated the resident was cognitively intact. The activities note, dated 2/23/23 at 8:33 a.m., indicated activities would provide leisure materials as needed and encourage group participation. He had done games and crafts with the group. During an interview on 4/19/23 at 2:02 p.m., Resident 35 indicated he would go to group activities but they never had any. There was never anyone out there to do them and they did not have group activities in his Villa. They had not offered to take him to other Villas for activities. They used to bring a calendar of activities to him but he had not received one in about two months. He would like to go to activities, he felt bored and stated, "Who wouldn't?" The Activities Calendar for Villas 2 thru 7, provided on 4/19/23 at 1:00 p.m. by the Executive Director, indicated on April 24 the following activities were to be provided: - Coffee Chat - Exercise in Villa 2 and Villa 6 - Room Visits - Card Bingo - Elder Council in Villa 5 During an observation, on 4/24/23 at 1:49 p.m., Resident 35 was sitting in his wheelchair in his room. The nurse was sitting in the office. No CNAs (Certified Nurse Aide) or activities staff were in sight and there were no activities being provided at the time. The resident indicated they had not invited him to any activities that day.			

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	The Activities Calendar for Villas 2 thru 7, provided on 4/19/23 at 1:00 p.m. by the Executive Director, indicated on April 25 the following activities were to be provided: - Mail/Paper Pass - Coffee Chat - Beauty Shop - Room visits - Crafts During an observation on 4/25/23 at 2:14 p.m., Resident 35 was sitting in the common area in his wheelchair watching television. There were no guided activities being conducted at the time and the resident indicated he had not been asked to attend any activities again that day. 4. The record for Resident 47 was reviewed on 4/24/23 at 2:00 p.m. The diagnoses included, but were not limited to, Alzheimer's disease with early onset, dementia, schizophrenia, major depressive disorder, anxiety disorder, and bipolar disorder. The care plan, initiated on 6/9/22, indicated the resident would participate in activities of interest. The interventions included, but were not limited to, resident was to participate in activities of her choosing until next review date, the resident was to socialize with staff and peers during meals, the resident would be put on the Library Program, encourage the resident to participate in activities of her choosing, provide a monthly activities calendar to follow, and staff to assist the resident to other Villas for activities as well. The Quarterly MDS assessment, dated 1/25/23, indicated the resident was moderately cognitively impaired. The activities note, dated 4/19/23 at 8:04 a.m.,			

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	indicated the resident had been participating in activities. The facility would continue to make her feel more comfortable to her new home and encourage her to attend all planned activities in her Villa and other Villas as well. She had attended bingo as a group also. Activities would continue to encourage participation. She enjoyed exercise club. During an interview on 4/19/23 at 11:26 a.m., Resident 47 indicated they did not have a lot of activities to do. The Activities Calendar for Villas 2 thru 7, provided on 4/19/23 at 1:00 p.m. by the Executive Director, indicated on April 21 the following activities were to be provided: - Mail/Paper Pass - Coffee Chat - Exercise - Room Visits - Bingo Villas 3 and 7 During an observation of Villa 7 on 4/21/23 at 10:10 a.m., there were no activities being provided and no activities staff in the Villa. Resident 47 was in her room watching television. The nurse was sitting at the desk charting. Only one resident was up, sitting in the common area conversing with a family member. All other residents were observed to be lying abed sleeping or watching television with no individualized activities being provided. During an interview on 4/21/23 at 10:15 a.m., CNA 13 indicated they were supposed to be having bingo at 2:30. Each Villa had a different activities director. During an observation on 4/21/23 at 10:16 a.m., the Activities Director entered Villa 7 and began			

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	155770	A. BUILDING 00 B. WING	04/26/2023

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VILLAS OF GUERIN WOODS	1002 SISTER BARBARA WAY GEORGETOWN, IN 47122

(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
	passing newspapers to resident rooms. She talked with each resident a few seconds to a few minutes before moving on to provide a paper to the next resident. The Activities Calendar for Villas 2 thru 7, provided on 4/19/23 at 1:00 p.m. by the Executive Director, indicated on April 24 the following activities were to be provided: - Coffee Chat - Exercise in Villa 2 and Villa 6 - Room Visits - Card Bingo - Elder Council in Villa 5 During an observation on 4/24/23 at 2:01 p.m., Resident 47 was sitting in her room in her chair. The resident was watching television and indicated she had not been invited to any activities so far that day. During an interview on 4/25/23 at 8:43 a.m., LPN 12 indicated the resident did like to go to group activities and had specifically asked to do exercise activities and calming music. She let the Activities Director know and she had started coming over. She was only at the villa 2 to 3 days a week, so she was not sure how often they were there to do activities, but they were not there every day. If CNAs had time throughout the day they'd try to engage in the residents in some activities. She believed Activities staff were supposed to be doing it. It said in the calendar what activities were due. Activities staff was not there on the weekend. 5. The record for Resident 50 was reviewed on 4/25/23 at 10:00 a.m. The diagnoses included, but were not limited to difficulty in walking, need for assistance with personal care.			

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	The care plan, dated 2/15/22, indicated the resident would participate in activities of his choosing. The interventions, dated 2/15/22, indicated to give the resident a monthly activities calendar to follow. Staff were to assist the resident out on the patio when weather permitted, the resident loved the outdoors. Staff were to encourage the resident to participate in activities of interest in his Villa and other Villas as well. Staff were to socialize with the resident during care and meals for socialization. The Activity Evaluation, dated 2/14/22, indicated the resident enjoyed activities with cards, games, sports, spending time outdoors, walking and wheeling outdoors, watching TV, radio, movies, gardening, and talking. The Quarterly MDS (Minimum Data Set) assessment, dated 4/7/22, indicated the resident was cognitively intact. He required extensive assistance of one person for transfer, locomotion, and walking. During an interview on 4/19/23 at 11:11 a.m., Resident 50 indicated they didn't let him know when bingo was and the calendar was too small and confusing. On 4/20/23 at 9:38 a.m., no activities were being conducted in Villa 4. Two residents were sitting in the common area and dining area. On 4/20/23 at 10:09 a.m., no activities were being conducted in Villa 6. Two residents were asleep. On 4/20/23 at 9:17 a.m., no activities were being conducted in Villa 6. One resident observed sleeping in the common area.			

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	On 4/20/23 at 1:29 p.m., no activities were being conducted in Villa 6. Residents were sitting in their rooms. On 4/20/23 at 1:35 p.m., no activities were being conducted in Villa 7. One female resident was reading a newspaper at the dining table and two male residents were sitting at the dining table asleep. On 4/20/23 at 1:40 p.m., no activities were being conducted in Villa 8. During an interview on 4/20/23 at 11:00 a.m., the Activities Director indicated the aides were to help with crafts, balloon toss, and noodle activities. They had a closet with the activity supplies in each Villa. The residents who were not involved in the activity going on did leisure activities. She was going to start bunco and tomato planting. She conducted room visits with the residents in the morning for mail pass. The women enjoyed euchre, but the men didn't attend. She indicated she didn't have times on the schedule, because it confused the residents. The times varied during the day, so it wasn't on the calendar. During an interview on 4/21/23 at 12:04 p.m., CNA 9 indicated the Activities Director came to the Villa and conducted activities of a ball toss, card games and things from the closet. The residents liked to take naps after breakfast by their choice. 2:00 p.m. to 3:00 p.m. was a slow time in the Villa. Activities were performed with the residents during the slow time. During an interview on 4/25/23 at 11:12 a.m., LPN 12 indicated the resident liked to socialize, but didn't like bingo. His vision was okay and he			

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	didn't required glasses. She felt he saw well enough to read the calendar and could read his big clock well. He was cognitive enough to know activities were going on. 6. During an interview on 4/19/23 at 10:50 a.m., Resident 45 indicated no activities were conducted in Villa 6. The clinical record for Resident 45 was reviewed on 4/19/23 at 1:05 p.m. The diagnoses included, but were not limited to, Parkinson's disease and dementia with behavioral disturbance. The care plan, dated 6/21/22 and was last revised on 7/14/22, indicated the resident was to participate in activities of interest. He received the paper daily. The resident enjoyed drinking coffee and socializes with staff and peers. The resident was also in up in his wheelchair at the hearth area and watched TV The interventions, dated 6/21/22, indicated to encourage the resident to attend all planned activities in his Villa and other Villas well. Encourage the resident to socialize with staff and other residents during meals. Provide the resident with daily newspaper for socialization and to keep up with the news. Staff were to assist the resident to all activities in his Villa and other Villas as well. The clinical record lacked documentation of an Activities Evaluation. The Annual MDS assessment, dated 3/4/23, indicated the resident was severely cognitively impaired. He required limited assistance of one person for transfers, supervision of one person for walking and locomotion. During an interview on 4/24/23 at 8:10 a.m., the Activities Director indicated she had added the			

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	times of activities to the schedule. In retrospect, she felt the times needed to be on there. During an interview on 4/25/23 at 10:55 a.m., LPN 12 indicated the resident's family member was a resident in the facility and he would visit her often. He was easy to redirect. He enjoyed reading the newspaper, watch TV and sit outside. During an interview on 4/25/23 at 11:15 a.m., Resident 45 indicated he had not seen any activities going on. He didn't know what activities were going on. He liked going out to places. The Activities Director Job Description, dated 6/15/22, was provided on 4/21/23 at 2:00 p.m., by the LPN/Unit Manager. The job description included, but was not limited to, "The primary purpose of the job position is to plan, organize, implement, evaluate and direct the Activity Programs in accordance with current Federal, State, and local standards governing the facility and as directed by Administrator, to ensure that the emotional, recreational, and social needs of the residents are met and maintained on an individual basis. As Activities Director, you are delegated the authority, responsibility, and accountability necessary for carrying out your assigned duties..." 3.1-33(a) 3.1-33(b)(3) 3.1-33(b)(5) 3.1-33(c) 3.1-33(d)(1) 3.1-33(d)(2) 3.1-33(d)(4)			
F 0686 SS=D	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure			

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Bldg. 00	Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review and interview, the facility failed to ensure a preventative device was placed timely to prevent the development of a pressure ulcer during the review of 1 of 4 pressure ulcers reviewed. (Resident 20) Findings include: The record was reviewed for Resident 20 on 4/20/23 at 9:49 a.m. The diagnoses included, but were not limited to, need for assistance with personal care, muscle weakness, contractures of the left and right ankles, osteoarthritis, dementia, polyneuropathy, type 2 Diabetes Mellitus, and intervertebral degeneration. The Interdisciplinary note, dated 12/8/22 at 11:31 a.m., indicated the resident returned to facility in 2019. She had a history of impaired skin and had fragile skin to the coccyx. The Quarterly MDS (Minimum Data Set) assessment, dated 2/2/23, indicated the resident was cognitively intact. She required extensive	F 0686	F 0686 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident #20 Air mattress has been replaced. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All residents have the potential to be affected by this practice. 2. A100 % audit of all resident records reviewed to ensure all preventative devices are in place as ordered/care planned.	06/01/2023

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	assistance of two staff for bed mobility, transfers, toileting and personal hygiene. The care plan, dated 2/4/22 and last revised on 5/27/22, indicated the resident had the potential for pressure ulcer development related to her disease process, a history of ulcers, and immobility. The interventions, dated 2/4/22, included, but were not limited to, administer treatments as ordered and observe for effectiveness, obtain an air mattress for pressure relief and check the function every shift, and assist with turning and repositioning PRN (as needed). The care plan, lacked any updated interventions related to the resident's nonfunctioning air mattress. The nurse's note, dated 2/24/23 at 10:35 a.m., indicated the resident's air mattress was nonfunctioning. Maintenance removed the air mattress and placed a regular mattress on the resident's bed until a new air mattress arrived. The nurse's note, dated 2/24/23 at 5:56 p.m., indicated the resident's perineal area and buttocks remained red. There were no new orders. The nurse's note, dated 2/26/23 at 10:35 p.m., indicated on the first bed check the resident had a new ulcer to the right buttock, measuring 0.5 cm (centimeters) long by 0.2 cm wide. The ulcer was actively bleeding. The NP (Nurse Practitioner) was notified. The treatment was ordered and a Mepilex dressing was applied. The resident would be seen by the NP and Wound NP the following day. The Wound Evaluation note, dated 2/27/23, indicated the resident's new wound to the right		3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. All staff have been educated on ensuring preventative devices are in place as ordered/care planned. 2. Department heads will check 3x week for 6 months to ensure preventative devices are in place as ordered/care/planned. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. The DON/designee will audit 3x week to ensure preventative devices are in place as ordered/care/planned. 2. A Performance Improvement Tool has been initiated to ensure preventative devices are in place as ordered/care planned. The DON/designee will complete this audit 5 days a week x 4 weeks then weekly x 8 weeks and then monthly x 3 months. Any issues identified will be immediately corrected. The QA committee will review the tool at regularly scheduled meetings and make additional recommendations as	

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	buttock measured 0.98 cm long by 1.26 cm wide by 0.1 cm deep. There was 100% granulation. The surrounding area was a fungal periwound. The treatment was Mary's magic cream two times daily and leave open to air. The nurse's note, dated 3/3/23 at 5:29 p.m., indicated the resident's new air mattress had arrived. Maintenance removed the regular mattress and put on new air mattress. The nurse's note, dated 3/3/23 at 4:47 p.m., indicated the resident required full staff assistance with all ADLs (Activities of Daily Living). She required a hoyer lift for all transfers. The buttocks continued to be red and the treatment cream was applied. The Wound Evaluation note, dated 3/6/23, indicated the wound to the right buttock measured 0.61 cm long by 0.69 cm wide by 0.1 cm deep with 100% granulation with 100% granulation tissue. The wound was improving. The Wound Evaluation note, dated 3/13/23, indicated the wound had healed. During an interview on 4/25/23 at 11:05 a.m., LPN 12 indicated the resident stayed in bed quite a bit and was incontinent, so she was prone to pressure ulcers more than the other residents. She was not compliant with turning and repositioning every 2 hours. She was able to take directions well. It took 24 hours to receive an air mattress. The nurse would put in the order for a new mattress, then the Maintenance Director would put the order in place. He would put on the new air mattress as soon as it arrived. The Skin and Wound Management System policy,		needed based on the outcome of the tool. The review of the tool as indicated above will increase to daily monitoring if less than 100%. The Quality Assurance Committee will continue to review the auditing tool until the tool shows 100% compliance, at which time the committee may decrease the monitoring increments. Non-compliance by an employee will result in additional education or corrective action up to and including termination. 5. Competition date: 6/1/23	

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	revised September 2022, was provided by the Unit Manager on 4/25/23 at 10:00 a.m., included, but was not limited to, "... 4. Preventative intervention will be implemented for residents identified at risk as appropriate, for example beds... 5. Residents identified with skin impairments will have appropriate interventions, treatment and services implemented to promote healing and impede infection..." 3.1-40(a)(2)			
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of			

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	records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 6. The record for Resident 16 was reviewed on 4/24/23 at 10:08 a.m. The diagnoses included but was not limited to rheumatoid arthritis. The nurse's note, dated 5/28/22 at 8:14 p.m., indicated the resident asked how much of her Humira was left when the nurse gave the resident her injection. The nurse indicated that was the resident's last dose in the refrigerator. Resident 16 indicated that her family member just brought some in and she should have a whole new box. The nurse rechecked in the refrigerator but did not find any. The nurse proceeded to check in the nurse's office and on the counters. She found the Humira box stuffed in a corner of the office above the refrigerator. She notified the resident who then notified her family member. The residents family member placed a call to the pharmacy to ask if the Humira injection was still good. Resident 16 and her family member were upset because the medication was not refrigerated when it was brought to the facility. The Annual MDS assessment, dated 11/16/22, indicated the resident was cognitively intact. The physician's order, dated 12/21/22, indicated to administer Humira pen-injector 40 mg (milligram) per 0.4 ml (milliliter) subcutaneously one time a day every 14 days related to rheumatoid arthritis.	F 0755	**F 0755** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Residents #269 and #16 are receiving the prescribed dose of medication, Narcotics have been signed out on the narc sheet for residents #2, #38, and #39 as medication is administered, and medications are properly labeled and stored properly. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All residents have the potential to be affected by this practice. 2. All resident medications have been reviewed to ensure that every medication has proper labeling, open dates, and stored properly. 3. Narcotic count sheets have been reviewed to ensure narcotic counts are correct. 3. What measures will be put into place and what systemic	06/01/2023

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	The nurse's note, dated 1/5/23 at 5:16 p.m., indicated the resident's family member called and asked if the resident's Humira injection had been given because the dose was not given on 1/3/23 as ordered. The NP (Nurse Practitioner was notified, and orders were received to give the injection now. The care plan, dated 4/11/23, indicated Resident 16 was on pain management therapy related to rheumatoid arthritis. The interventions included, but were not limited to, the resident would be free of any discomfort or adverse side effects from pain medication, administer the medication as ordered. During an interview on 4/21/23 at 12:15 p.m., QMA (Qualified Medication Aide) 19 indicated if a medication dose was missed the NP and family would be notified. She would receive orders from the NP and give the missed medication if indicated. The missed dose would be documented in the nurse's progress notes and the MAR (Medication Administration Record) with a note to why the dose was not given. When a medication was received for the pharmacy that had to be refrigerated the staff taking the medication should put it in the refrigerator immediately. The medication should never be left out. If the Villa did not have a refrigerator, they would take the medication to their sister Villa. There would be no reason to leave a refrigerated medication just lying on the shelf or cabinet. During an interview on 4/26/23 at 8:59 a.m., LPN 5 indicated if a medication was missed, she would call the doctor, DON (Director of Nursing) and the resident's family. She would follow the doctors' orders if any were given. The resident would be monitored for any side effects of not receiving the		changes will be made to ensure that the deficient practice does not recur. 1. All licensed nurses and QMA's have been educated on ensuring all medications have proper labeling, open dates, signing out narcotics on the narcotic count sheet as they are pulled to be administered, and following the 5 Rights of Medication Administration. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. The DON/designee will audit all resident medications to ensure proper labeling, open dates identified, and narcotic sheets are signed as narcotics are removed to be administered 2. A Performance Improvement Tool has been initiated to ensure Narcotics are signed out on the narcotic count sheet as they are pulled to be administered and all medications are properly labeled, have open dates and narcotic count sheets are signed as narcotics are pulled to be administered. The DON/designee will complete this audit weekly x 4 weeks, then bi-monthly x 5 months. Any issues identified will be immediately corrected. The QA committee will review the tool at regularly scheduled meetings and make additional recommendations	

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	medication. The reason for the missed dose should be documented in the MAR and the progress notes. The Medication Orders policy, last revised November 2014, provided on 4/25/23 at 10:00 a.m., by the Unit Manager, included, but was not limited to, "... 2. A current list of orders must be maintained in the clinical record of each resident..." 3.1-48(c)(1)Based on observation, record review, and interview, the facility failed to administer correct medication dose as prescribed for (Residents 269 and 16), ensure documentation in the Narcotic Count Sheet of administered narcotics for (Residents 2, 39, and 38) and proper labeling and storage for (Villa 2 Medication Cart) for 6 of 20 pharmacy services reviewed. Findings include: 1. The record for Resident 269 was reviewed on 4/24/23 at 9:42 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure, heart disease, atrial fibrillation, hypotension, other cardiomyopathies and presence of cardiac defibrillator. The Admission MDS (Minimum Data Set) assessment, dated 4/18/23, indicated the resident was cognitively intact. The Hospital Discharge Summary, dated 4/14/23, indicated the resident had been treated for congestive heart failure. She had been having the symptoms for the last several weeks and months and had been getting progressively worse. She had a known ejection fraction of 21% (percent) to 25% on recent testing. She was referred to		as needed based on the outcome of the tool. The review of the tool as indicated above will increase to daily monitoring if less than 100%. The Quality Assurance Committee will continue to review the auditing tool until the tool shows 100% compliance, at which time the committee may decrease the monitoring increments. Non-compliance by an employee will result in additional education or corrective action up to and including termination. 5. Competition date: 6/1/23	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	rehabilitation for therapy to treat her overall weakness. New medications on discharge included empagliflozin (Jardiance) 10 mg tablet once daily to start on April 15, 2023. The Physician's assessment, dated 4/14/23 at 3:32 a.m., indicated the resident was a new admit to the facility and her medications were reviewed. The care plan, initiated on 4/14/23, indicated the resident had congestive heart failure. The interventions included, but were not limited to, administer cardiac medications as ordered. The clinical record lacked documentation of any orders for Jardiance being transcribed upon the resident's admission, or any orders to discontinue the medication. During an interview on 4/19/23 at 1:43 p.m., Resident 269 indicated she had congestive heart failure and her heart did not pump right. She had been at the hospital because of it and her Cardiologist had ordered Jardiance while she was there because it had a side effect to help with heart failure. She had not received it since coming to the facility and a nurse had told her she did not see an order for the resident to receive it. During an interview on 4/24/23 at 2:28 p.m., the Unit Manager indicated the resident's Jardiance order should have been started unless they were instructed otherwise, which should have been indicated in the clinical record. During an interview on 4/26/23 at 11:16 a.m., LPN (Licensed Practical Nurse) 7 indicated when a resident admitted they reviewed the admission packet and faxed the orders to the pharmacy. She would put them in the system and have night shift			

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	155770	A. BUILDING 00 B. WING	04/26/2023

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	double check her. On the discharge summary all medications should be put into the system. They did not have a process of documenting the double check. They should probably put it in a nurse's note. During an interview on 4/26/23 at 11:57 a.m., the Unit Manager indicated the unit nurse would put the admission orders in unless for some reason another staff member was assisting. The resident's discharge summary did have the Jardiance on it. The medication should have been prescribed when she admitted. When they got the summary they would review it with the family, and the on-call Nurse Practitioner. Then they would review the orders, get the approval, and fax them to pharmacy. The order was faxed to pharmacy but it did not make it onto the resident's orders. 2. a. During an observation on 4/25/23 at 2:15 p.m., of the Villa 2 medication cart with QMA (Qualified Medication Aide) 14, Resident 38's Norco 5/325 mg (milligram) Controlled Substances Record sheet indicated the resident had a count of 25 tablets left. The last dose signed out was on 4/24/23 at 8:00 p.m. The resident's medication card only contained 24 tablets of the medication. Resident 38's alprazolam 0.25 mg Controlled Substances Record sheet indicated the resident had a count of 22 tablets left. The last dose signed out was on 4/24/23 at 8:00 p.m. The resident's medication card only contained 21 tablets of the medication. During an interview on 4/25/23 at 2:17 p.m., QMA 14 indicated she had given the resident both medications at 8:00 a.m. and had forgotten to sign them out. She was supposed to sign narcotics out as soon as residents took them.			

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	The clinical record for Resident 38 was reviewed on 4/25/23 at 2:30 p.m. The diagnoses included, but were not limited to, anxiety disorder and chronic pain syndrome. The physician's order, dated 11/4/22, indicated the resident received Norco 5/325 mg 1 tablet by mouth every 4 hours as needed and 1 tablet twice daily routinely for pain. The physician's order, dated 11/5/22, indicated the resident received alprazolam 0.25 mg 1 tablet twice daily for anxiety. The resident's MAR (Medication Administration Record), indicated the resident received a dose of both Norco 5/325 mg and alprazolam 0.25 mg on 4/25/23 at 8:00 a.m. b. During an observation on 4/25/23 at 2:33 p.m. of the Villa 3 medication cart with LPN 15, Resident 38's Norco 10/325 mg Controlled Substances Record sheet indicated the resident had a count of 3 tablets left. The last dose signed out was on 4/25/23 at 6:00 a.m. The resident's medication card only contained 1 tablet of the medication. During an interview on 4/25/23 at 2:37 p.m., LPN 15 indicated she had given the resident the medication at 12:00 p.m. and had also sent a dose of the medication with the resident, as she went on a leave of absence and would not be at the facility for her 6:00 p.m. dose. She had not signed either of the doses out on the Controlled Substances Record sheet. The physician's order, dated 4/12/23, indicated the resident received Norco 10/325 mg every 6 hours for pain.			

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	The resident's MAR indicated the resident received a dose of the Norco 10/325 mg on 4/25/23 at 12:00 p.m. During an interview on 4/25/23 at 2:41 p.m., LPN 15 indicated she had administered all of the medications to the residents, but had not signed them out. She was really bad about that. 3. During an observation on 4/25/23 at 2:19 p.m., of the Villa 2 medication cart with QMA (Qualified Medication Aide) 14, located in the top drawer of the cart there were two opened bottles of fluticasone 50 mg/act (milligrams per actuation) nasal spray in the medication cart. One of the bottles was half empty. Neither of the bottles contained any pharmacy labeling, an open date, or resident information on them. There was a Levemir flex-pen in the top drawer of the medication cart with no open date, expiration date, resident information or pharmacy labeling on the pen. During an interview on 4/25/23 at 2:20 p.m., QMA 14 indicated the medication should have the resident's information on them and the dates they were opened. She did not know who they belonged to or how long they had been in the cart. 4. During an observation on 4/25/23 at 2:33 p.m. of the Villa 3 medication cart with LPN 15, Resident 2's Norco 10/325 mg Controlled Substances Record sheet indicated the resident had a count of 25 tablets left. The last dose signed out was on 4/25/23 at 6:00 a.m. The resident's medication card only contained 24 tablets of the medication. During an interview on 4/25/23 at 2:35 p.m., LPN 15 indicated she had given the resident the			

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	medication at 12:00 p.m. and had not signed it out. The clinical record for Resident 2 was reviewed on 4/25/23 at 2:40 p.m. The diagnoses included, but were not limited to, fibromyalgia and osteoarthritis. The physician's order, dated 10/26/22, indicated the resident received Norco 10/325 mg every 6 hours for pain. The resident's MAR indicated the resident received a dose of the Norco 10/325 mg on 4/25/23 at 12:00 p.m. 5. During an observation on 4/25/23 at 2:35 p.m., of the Villa 3 medication cart with LPN 15, Resident 39's clonazepam 0.5 mg Controlled Substances Record sheet indicated the resident had a count of 18 tablets left. The last dose signed out was on 4/23/23 at 2:00 p.m. The resident's medication card only contained 16 tablets of the medication. During an interview on 4/25/23 at 2:36 p.m., LPN 15 indicated she had given the resident 2 tablets at 2:00 p.m. The clinical record for Resident 39 was reviewed on 4/25/23 at 2:45 p.m. The diagnoses included, but were not limited to, psychotic disorder with delusions, major depressive disorder, and anxiety disorder. The physician's order, dated 3/7/23, indicated the resident received 2 tablets of clonazepam 0.5 mg every day at 2:00 p.m. for anxiety. The resident's MAR indicated the resident received two tablets of the clonazepam 0.5 mg as			

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	ordered on 4/25/23 at 2:00 p.m. The Controlled Medication Storage policy, last revised 5/20/20, provided on 4/26/23 at 2:00 p.m. by the Executive Director, included but was not limited to, " ... 1. Regulations require that the facility have a system to account for the receipt, usage, disposition, and reconciliation of all controlled medication(s). The system includes but is not limited to ... b. Records of all usage and disposition of all controlled medication(s) with sufficient detail to allow reconciliation..." The Storage of Medications and Biologicals policy, last revised 5/20/20, provided on 4/26/23 at 2:00 p.m. by the Executive Director, included, but was not limited to, " ... 1. The pharmacy dispenses medication(s) in containers that meet legal requirements ... a. Medication(s) are to be kept in these containers ..." 3.1-25(b)(3) 3.1-25(k)(1) 3.1-25(k)(2) 3.1-25(k)(3) 3.1-25(k)(5) 3.1-25(k)(6) 3.1-25(k)(7)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure the physicians' orders were transcribed accurately to pharmacy for timely administration for 2 of 7 residents reviewed for significant medication errors. (Residents 50 and 34)	F 0760	**F 0760** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	06/01/2023

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	Findings include: 1. The clinical record for Resident 50 was reviewed on 4/25/23 at 10:00 a.m. The diagnoses included, but were not limited to difficulty in walking, need for assistance with personal care, methicillin resistant staphylococcus aureus infection, retention of urine, and BPH (benign prostatic hyperplasia). The care plan, dated 2/10/22, indicated the resident had a diagnosis of BPH. The interventions indicated to provide intermittent catheterization per the MD (medical doctor) order, to notify the MD of concerns or changes PRN (as needed), and to provide a urology consult as needed. The Quarterly MDS (Minimum Data Set) assessment, dated 5/19/22, indicated the resident was cognitively intact. He required limited assistance of one person for bed mobility and supervision of one person for toilet use. The nurse's note, dated 5/21/22 at 4:50 a.m., indicated the resident had an enlarged prostate, but had voided well with a urinal. His urine was clear yellow. A call was placed to the NP, and an order was received to obtain a U/A (urinalysis). The urinalysis culture report, dated 6/7/22, indicated greater than 100,000 CFU/ml (colony forming units per milliliter) enterococcus faecalis VRE (Vancomycin Resistant Enterococci). The physician's orders, dated 6/8/22, indicated to administer sulfamethoxazole-trimethoprim (Bactrim) tablet 800-160 mg (milligrams) one tablet every 12 hours for a UTI (urinary tract infection)		1. Physician orders for resident #50 and resident #34 were clarified and the resident received their medication as prescribed. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All residents have the potential to be affected by the deficient practice. 2. An audit was completed to validate the accuracy of the past 30 days of new physician orders and past 30 days of new chart reviews to identify inaccurate transcription of physician orders. The orders were clarified as identified. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. Licensed nursing staff have been re-educated on transcribing physician orders accurately. 2. The IDT have been re-educated on new admission chart reviews and transcribing orders accurately. 3. Physician orders for new	

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	for 7 days. The nurse's note, dated 6/10/22 at 4:38 p.m., indicated the resident's culture and sensitivity results were sent to the NP (Nurse Practitioner). A new order per the NP to discontinue the Bactrim and start Macrobid 100 mg twice daily for 7 days for the UTI. The Infection note, dated 6/13/22 at 6:16 a.m., indicated to continue the antibiotic for the UTI. The resident's urine was clear, light straw colored. The Interdisciplinary note, dated 6/13/22 at 1:32 p.m., indicated the resident refused to be catheterized per the urology order. The resident was educated on the results of his urinalysis and discussed that not cathing would be the culprit of his VRE. The nurse's note, dated 6/14/22 at 8:09 p.m., indicated a family member inquired about the name of the antibiotic the resident was prescribed. The nurse examined the MAR (Medication Administration Record) and TAR (Treatment Administration Record) and observed no antibiotics were to be administered that shift. After further investigating the issue, the medication order was entered to be administered two times every 7 days rather than two times everyday for 7 days. The physician's order, dated 6/24/22 at 3:21 p.m., indicated the order was entered for Levaquin 500 mg. Give 1 tablet by mouth one time a day for the UTI for 7 days. The nurse's note, dated 6/24/22 at 5:52 p.m., indicated the resident had an appointment that day with a urology company and he came back		admissions will be reviewed by the IDT to validate the transcribed physician orders are accurate and as ordered by the physician. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. The DON/designee will audit all resident progress notes daily to ensure there is Physician notification for any change of condition. 2. A Performance Improvement Tool has been initiated to ensure there is Physician notification for any resident change in condition. The DON/designee will complete this audit daily x 6 months. Any issues identified will be immediately corrected. The QA committee will review the tool at regularly scheduled meetings and make additional recommendations as needed based on the outcome of the tool. The review of the tool as indicated above will increase to daily monitoring if less than 100%. The Quality Assurance Committee will continue to review the auditing tool until the tool shows 100% compliance, at which time the committee may decrease the monitoring increments. Non-compliance by an employee will result in additional education	

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	with new orders for Levaquin 500 mg daily as well as to discontinue the three times daily in and out catheterization. The infection note, dated 6/25/22 at 12:00 a.m., indicated the resident remained in contact isolation for VRE in the urine. His Bactrim had been discontinued and a new order for Levaquin was given. The medication should be delivered this night. The infection note, dated 6/26/22 at 3:36 a.m., indicated the resident remained in contact precautions due to VRE in the urine. He was started on Levaquin on 6/25/22 and would continue once per day. 2. The clinical record for Resident 34 was reviewed on 4/21/23 at 9:45 a.m. The diagnosis included, but were not limited to, urinary tract infection, acute kidney failure, need for assistance with personal care, muscle weakness, and dementia. The care plan, dated 10/18/22 and last revised on 4/20/23, indicated the resident had a current UTI and required IV (intravenous) antibiotics. The interventions, dated 10/18/22, indicated to provide antibiotic therapy as ordered and observe and document for side effects and effectiveness. The Quarterly MDS, dated 12/1/22, indicated the resident was moderately cognitively impaired. She required extensive assistance of two persons for bed mobility, transfer, and toilet use. The urinalysis, dated 4/12/23, indicated the urine was turbid, positive for nitrites, 4 plus leukocytes, greater than 50 hpf (high power field) wbc (white blood cell count), with moderate bacteria. The		or corrective action up to and including termination. 5. Competition date: 6/1/2023	

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	culture indicated greater than 100,000 CFU/mL proteus mirabilis. The culture indicated the bacteria was susceptible to ceftriaxone (Rocephin). The physician's note, dated 4/13/23 at 2:12 p.m., indicated the physician reviewed the UA, which indicated moderate bacteria plus nitrates. The physician ordered a midline, normal saline at 100 milliliters per hour and Rocephin 1 gram intravenously, daily for 7 days. Once the UA culture was received, the antibiotic would be changed if necessary. The April MAR (Medication Administration Record) indicated an order for Ceftazidime intravenous solution reconstituted. Use 1 gram intravenously at bedtime every 7 day(s) for infection until 4/20/23 at 8:01 p.m. Infuse medication reconstituted in 100 ml normal saline, rate 200 ml/hr with a date of 4/13/23. The start date was 4/14/23. The order was discontinued on 4/13/23. The antibiotic was administered on 4/14/23. The clinical record lacked documentation of administration of the ceftazidime or Rocephin on 4/15/23 or 4/16/23. The nursing note, dated 4/16/23 at 3:43 p.m., indicated a new order to continue the IV (intravenous) antibiotic for 7 days. The April MAR indicated an order for Ceftriaxone sodium injection solution reconstituted 1 gram. Use 1 gram intravenously one time a day for UTI until 4/22/23 at 11:59 p.m., with a start date of 4/17/23 at 2:10 p.m. The antibiotic was administered on April 17, 18, 19, and 20.			

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	The nurse's note, dated 4/16/23 at 11:09 p.m., indicated the nurse found a medication transcribe error. The Ceftriaxone order was placed in the computer for every 7 days. This was verified with the NP. The order was re-written for one dose that night on 4/16/22, then discontinue the order per the nurse practitioner and DON (Director of Nursing). The nurse's note, dated 4/17/23 at 12:29 p.m., indicated a family member was called and notified of the resident not receiving her intravenous antibiotic on Saturday due to the order being put in incorrectly. The family member was told of the new order and the stop date. During an interview on 4/25/23 at 12:57 p.m., the Unit Manager indicated the order for the resident was put into place correctly, but the agency nurse re-entered the order 6 times incorrectly. The incorrect order was kept in place for pharmacy. During an interview on 4/25/23 at 11:10 a.m. LPN (Licensed Practical Nurse) 12, indicated the resident was prone to UTIs. She was incontinent, immobile, and would sit up in her recliner. She stayed in bed most of the time. She had UTIs for years. Both the MD and NP ordered medications. New orders were placed in the computer by the nurse, under orders, and it was sent to pharmacy. The Medication Orders policy, last revised November 2014, was provided on 4/25/23 at 10:00 a.m., by LPN/Unit Manager. The policy included, but was not limited to, "... Recording Orders 1. When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered... 6. Treatment Orders-When recording treatment orders, specify the treatment, frequency and duration of the treatment..."			

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	3.1-48(c)(2)			
F 0886 SS=D Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for			

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	conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.			
	Based on record review and interview, the facility failed to ensure the residents were COVID-19 tested in accordance with their policy for 2 of 23 residents reviewed for COVID testing. (Residents 43 and 17) Findings include:	F 0886	**F 0886** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.1. Resident #17 and #43 will be evaluated for COVID-19 in accordance with the testing	06/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155770	A. BUILDING 00 B. WING	04/26/2023

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	1. The clinical record for Resident 43 was reviewed on 4/24/23 at 10:13 a.m. The diagnoses included, but were not limited to, Parkinson's disease, personal history of COVID-19, and dysphagia. The Quarterly Minimum Data Set (MDS) assessment, dated 2/15/23, indicated the resident was alert and oriented. On 1/10/23, a new physician's order was received for COVID testing every 24 hours as needed. The Nurse's note, dated 3/1/23 at 6:33 a.m., indicated the resident no longer had nausea, vomiting or loose stools. The nursing note, dated 3/2/23 at 3:48 a.m., indicated the resident had intravenous fluids running although was taking fluids well. The clinical record lacked documentation of the resident having been COVID tested when experiencing symptoms. During an interview on 4/24/23 at 11:33 a.m., Unit Manager, indicated if a resident was experiencing any symptoms related to COVID, they should be immediately tested as that was the reason for the PRN (as needed) order to test for COVID. During an interview on 4/24/23 at 1:29 p.m., LPN (Licensed Practical Nurse) 11 indicated she would monitor for any change in vital signs, in eating and bowel habits, fever, cough, and respiratory distress and COVID test the resident if they displayed symptoms. 2. The clinical record for Resident 17 was reviewed on 4/24/23 at 9:53 a.m. The diagnosis included, but was not limited to, chronic obstructive pulmonary		requirements related to signs and symptoms. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.1. All residents have the potential to be affected by this practice.2. All resident medications have been reviewed to ensure that every medication has proper labeling and open dates. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.1. Staff have been re-educated on the requirements of COVID-19 testing as indicated by the resident's signs and symptoms. 2. The DON/designee will review each residents' nurses' notes and their documented vitals daily to identify residents that need to be evaluated for COVID-19 in accordance with the established guidelines. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.1. The DON/designee will audit all resident records to ensure those who have signs or symptoms of COVID-19 are evaluated.2. A Performance Improvement Tool has been initiated to ensure residents with signs or symptoms	

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	disease. The Quarterly MDS assessment, dated 3/24/23, indicated the resident was severely cognitively impaired. On 2/6/23, a new physician's order was received for Albuterol Sulfate Inhalation Nebulization Solution 2.5 mg (milligrams)/3 ml (milliters) 0.083%. Staff were to administer 2.5 mg inhale orally every 6 hours as needed for wheezing or shortness of air. On 2/7/23, the resident received two new physician orders: COVID test, one time only, to rule out COVID for 1 day and as needed for s/s (signs/symptoms) of COVID; and obtain temperature and oxygen saturation every day and night shift for COVID requirements. The nurse's note, dated 3/20/23 at 4:12 p.m., indicated the resident had nasal/chest congestion, cough and some notable abnormal lung sounds. The current oxygen saturations were within normal limits for the resident. The Nurse Practitioner ordered an X-ray to rule out pneumonia or other lung cardiac issues. The clinical record lacked documentation of the resident having been COVID tested when experiencing symptoms. On 4/19/23 at 1:00 p.m., the Executive Director presented a copy of the facility's current Coronavirus (COVID-19) policy dated 3/11/22. The policy included, but was not limited to, "...Overview...The response to the current outbreak of the Coronavirus disease and all infection prevention and control measures are based on the most current national standards and		of COVID-19 are evaluated. The DON/designee will complete this audit daily x 6 months. Any issues identified will be immediately corrected. The QA committee will review the tool at regularly scheduled meetings and make additional recommendations as needed based on the outcome of the tool. The review of the tool as indicated above will increase to daily monitoring if less than 100%. The Quality Assurance Committee will continue to review the auditing tool until the tool shows 100% compliance, at which time the committee may decrease the monitoring increments. Non-compliance by an employee will result in additional education or corrective action up to and including termination. 5. Competition date: 6/1/23	

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	recommendations from health policy officials, state agencies and the federal government and may change this interim guidance... Staff and Patient Surveillance, Testing and Reporting... Surveillance: Monitor patients for symptoms of respiratory infection and fever upon admission, daily, and/or as needed per the most current CDC (Center for Disease Control), Federal, State and or Local Guidance, and implement appropriate infection prevention practices as required...Testing: Testing of Staff and residents is to be completed as per the most current CDC, Federal, State, and or local guidance..."			
F 9999 Bldg. 00	3.1-13(w) Administration and Management: In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social services profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the	F 9999	**F 9999** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. LPN's 5, 6, 7, 8, RN 8, CNA 9, and CNA 10 have received Resident Rights, Abuse education and completed the required dementia training. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. 100% audit of all staff	06/01/2023

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	155770	A. BUILDING 00 B. WING	04/26/2023

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	current standards of care for residents with dementia. This State Rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure employees dementia, resident rights, and abuse training were completed as required for employees for 6 of 10 personnel files. (LPN 5, LPN 6 , LPN 7, RN 8, CNA 9 and CNA 10) Findings include: The review of the Personnel files on 4/24/23 at 1:00 p.m. indicated the following: LPN (Licensed Practical Nurse) 5, LPN 6 , LPN 7, RN 8, CNA (Certified Nurse Aide) 9 and CNA 10 lacked documentation of any resident rights and abuse inservicing, and the required hours for Dementia training. During an interview on 4/25/23 at 1:18 p.m., the Unit Manager indicated they did not do in-person inservices. They did paper inservices where each Villa had their own copies which went into medical records, but the problem was they did not have medical records staff so it was not being returned to him. He did not have proof of inservices for any of the requested employees and could not provide them. The most current but undated, facility Onboarding Policy & Procedure, provided on 4/26/23 at 11:01 a.m. by the Director of Nursing, included, but was not limited to, "... During orientation, all employees will receive the required training for abuse, Resident Rights, safety, HIPAA, and all other required in-servicing per state guidelines. After the initial facility orientation, the new hire will complete the 6-hour dementia training..."		records completed to identify those needing Resident Rights, Dementia, and abuse training. 3. Those identified as needing Resident Rights, Dementia and Abuse education have been completed and documented accordingly. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. HR director has been educated on completing required annual and new hire in-services/training on Resident Rights, Dementia and Abuse. 2. All newly hired employees will complete the required Resident Rights, Dementia and Abuse training upon hire. 3. All staff will have the required annual Resident Rights, Dementia and Abuse training scheduled for completion and monitored by HR Director. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. The ED/designee will audit	

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			the employee records weekly to ensure completion of required resident Rights, Dementia and Abuse training. 2. A Performance Improvement Tool has been initiated to ensure all employees have completed the required Resident Rights, Abuse and Dementia training. The ED/designee will complete this audit Weekly x 6 months. Any issues identified will be immediately corrected. The QA committee will review the tool at regularly scheduled meetings and make additional recommendations as needed based on the outcome of the tool. The review of the tool as indicated above will increase to daily monitoring if less than 100%. The Quality Assurance Committee will continue to review the auditing tool until the tool shows 100% compliance, at which time the committee may decrease the monitoring increments. 5. Competition date:	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of	R 0000	**Plan of Correction for the Villas of Guerin Woods from the April 26, 2023, Recertification and**	

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	Complaint IN00406320. Complaint IN00406320 - No deficiencies related to the allegations are cited. Survey dates: April 19, 20, 21, 24, 25, and 26, 2023. Facility number: 011509 Residential Census: 9 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 1, 2023.		**State Licensure with State Residential Licensure and Complaint Survey** The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of the Post Survey Revisit.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel			

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	shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to maintain a minimum of one staff member on duty with current First Aid certification 24 hours a day for 8 of 8 days reviewed. This deficient practice had the potential to affect all 9 residents currently residing in the facility. Findings include: The review of the staff schedule for April 19, 20, 21, 22, 23, 24, 25, and 26, 2023 indicated there were no staff in the facility with First Aid certification. During an interview on 4/26/23 at 9:20 a.m.., the Nurse Consultant indicated they did not know the Assisted Living facility requirement for one awake staff member available 24 hours per day to have First Aid. During an interview on 4/26/23 at 11:49 a.m., the Nurse Consultant indicated they could not locate any First Aid certifications. During an interview on 4/26/23 at 11:52 a.m., the Executive Director indicated they did not have First Aid certifications.	R 0117	**R 0117** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. There is an employee member that holds a current First Aid Certification on the Villas of Guerin Woods campus 24 hours a day. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents in Villa 1 (AL) have the potential to be affected by this practice. 2. A 100% Audit of all staff records was completed to identify those needing First aid Certification. 3. Those identified as needing First Aid certifications have been scheduled for completion. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.	06/01/2023

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			1. All Nurse management will be educated on the regulation/need to have a staff member on the campus with a current First Aid certification 24 hours a day. 2. All nursing staff will have First Aid training to ensure there is 24-hour coverage for an employee with the First Aid training certification. 3. First Aide certification will be scheduled for new employees as needed. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. The DON/designee will audit the daily nursing schedule to ensure there is a staff member on duty with a current First Aid certification 24 hours a day. 2. A Performance Improvement Tool has been initiated to ensure there is a staff member on campus that is First Aid Certified 24 hours a day. The DON/designee will complete this audit daily x 4 weeks then weekly x 8 weeks and then monthly x 3 months and quarterly x 2. Any issues identified will be immediately corrected. The QA	

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			committee will review the tool at regularly scheduled meetings and make additional recommendations as needed based on the outcome of the tool. The review of the tool as indicated above will increase to daily monitoring if less than 100%. The Quality Assurance Committee will continue to review the auditing tool until the tool shows 100% compliance, at which time the committee may decrease the monitoring increments. 5. Competition date: 6/1/2023	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.			

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	(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on record review and interview, the facility failed to ensure employees dementia, resident rights, and abuse training were completed as required for employees for 6 of 10 personnel files. Findings include: The review of the Personnel files on 4/24/23 at 1:00 p.m. indicated the following: LPN (Licensed Practical Nurse) 5, LPN 6 , LPN 7, RN 8, CNA (Certified Nurse Aide) 9 and CNA 10 lacked documentation of any resident rights and abuse inservicing, and the required hours for Dementia training. During an interview on 4/25/23 at 1:18 p.m., the Unit Manager indicated they did not do in-person inservices. They did paper inservices where each Villa had their own copies which went into medical records, but the problem was they did not have medical records staff so it was not being returned	R 0120	**R 0120** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. LPN's 5, 6, 7, 8, RN 8, CNA 9, and CNA 10 have received Resident Rights, Abuse education and completed the required dementia training. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this practice.	06/01/2023

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	to him. He did not have proof of inservices for any of the requested employees and could not provide them. The most current but undated, facility Onboarding Policy & Procedure, provided on 4/26/23 at 11:01 a.m. by the Director of Nursing, included, but was not limited to, "... During orientation, all employees will receive the required training for abuse, Resident Rights, safety, HIPAA, and all other required in-servicing per state guidelines. After the initial facility orientation, the new hire will complete the 6-hour dementia training..."		2. 100% audit of all staff records completed to identify those needing Resident Rights, Dementia, and abuse training. 3. Those identified as needing Resident Rights, Dementia and Abuse education have been completed and documented accordingly. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. HR director has been educated on completing required annual and new hire in-services/training on Resident Rights, Dementia and Abuse. 2. All newly hired employees will complete the required Resident Rights, Dementia and Abuse training upon hire. 3. All staff will have the required annual Resident Rights, Dementia and Abuse training scheduled for completion and monitored by HR Director/designee. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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			program will be put into place. 1. The ED/designee will audit the employee records weekly to ensure completion of required resident Rights, Dementia and Abuse training. 2. A Performance Improvement Tool has been initiated to ensure all employees have completed the required Resident Rights, Abuse and Dementia training. The ED/designee will complete this audit Weekly x 6 months. Any issues identified will be immediately corrected. The QA committee will review the tool at regularly scheduled meetings and make additional recommendations as needed based on the outcome of the tool. The review of the tool as indicated above will increase to daily monitoring if less than 100%. The Quality Assurance Committee will continue to review the auditing tool until the tool shows 100% compliance, at which time the committee may decrease the monitoring increments. 5. Competition date: 6/1/2023	