STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155858	A. BUILDING 00 B. WING	11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF WHITESTOWN, THE	6712 RESTORACY DRIVE WHITESTOWN, IN 46075

(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. Survey dates: October 30, 31 and November 1, 2, and 3, 2023 Facility number: 014586 Provider number: 155858 AIM number: 300040744 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 7 Medicaid: 34 Other: 23 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 14, 2023.	F 0000	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. We would like to request a desk review for the 689, 693, 761 and 9999 citations and an IDR for the 725 citation.	
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 to prevent accidents.			

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

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	Based on observation, interview, and record review, the facility failed to ensure a resident, (Resident 18) who required the use of a posture support harness/mobility device received routine and ongoing assessments and monitoring of the device to prevent the potential for accidents for 1 of 2 residents reviewed for positioning. Findings include: On 10/31/23 at 1:29 p.m., Resident 18 was observed. She was seated in an electric wheelchair with an adjustable harnessed strap buckled across her sternum. On 11/1/23 at 11:17 a.m., Resident 18's medical record was reviewed. She was aa long term care resident with diagnoses which included, but were not limited to, multiple sclerosis, history of stroke and muscle spasms. An Occupation Therapy (OT) Discharge summary indicated Resident 18 had received treatment and services between 9/23/22 and 12/15/22. During that time, she received a new harness for her wheelchair. "New harness equipment ordered and tilt chair modified by power mobility company with assistance from OT to facilitate." At the time of her discharge on 12/15/22, she still required partial to moderate assistance to put on the harness ... assist to don [put on] harness, able to operate power mobility once hoyered and positioned in chair ...." She had a physician's order, dated 4/4/23, which indicated, "may use positioning strap to chest due to poor trunk control related to multiple sclerosis." The physician's order lacked specific/special instructions which may need consideration upon	F 0689	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to appropriately assess the need, appropriateness, installation, functioning and/or integrity of a resident's positioning harness. **Corrective Action for resident(s) found to have deficient:** Resident 18 has been reevaluated and her comprehensive care plan now includes the task to assess the need, appropriateness, installation, functioning and/or integrity of her positioning harness. **Identify other residents having the same potential deficient:** Audit completed of in-house residents and no other residents use a device for harnessing themselves to a wheelchair. **Measures put into place or systemic changes:** The Director of Nursing, Therapy Director or designee will provide education to	12/04/2023

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	placement, duration of use, and removal of the device. She had a comprehensive care plan, initiated 4/9/21 and revised on 8/16/23. The care plan indicated Resident 18 had an Activities of Daily Living (ADL) self-care performance deficit related to multiple sclerosis. An intervention for the use of her positioning strap was not included on her plan of care until 4/5/23 (approximately 4 months after it had been installed). On 11/2/23 at 9:00 a.m., the Director of Nursing (DON) provided a copy of the harness' manufacture's instructions titled, "H-Style Shoulder Harness," dated 2020. The instructions indicated, " ...Caution: whenever an anterior trunk support is used, a properly adjusted pelvic support should also be worn to prevent sliding ... because of the risk of choking, it is dangerous to use this product without stabilizing the pelvis-always use with a properly fitted pelvic support belt ... this harness must be properly fitted to support the user's trunk and shoulders without causing injury. Have your seating specialist demonstrate its proper adjustment and use. A Harness that is too tight can restrict respiration and increase pressure across the shoulders and chest. A harness that is too loose can allow the user to slip down and may create a risk of strangulation. Accidental release of this shoulder harness can allow the use to fall forward. A user's inability to self-release can be hazardous if the user slips down or is strapped in the chair in an emergency. As with any new seating support, this product may change the way a person sits. Users must continue to practice regular pressure relief activities and skin integrity checks, not only where this product contacts the use but also in primary pressure-bearing areas such as the		the license nurses regarding: 1 Placement, positioning, functioning and ongoing monitoring and assessment of the harness. 2 Daily monitoring to check the harness and skin integrity **Plan to monitor performance to maintain compliance:** The Director of Nursing, Assistant Director of Nursing or designee will perform an audit that the order for placement, positioning, functioning and ongoing monitoring and assessment of the harness was completed weekly x 4 weeks, then monthly x 5 months. If any compliance trends are identified, they will be reviewed in QAPI meetings. **Date of Compliance: 12/4/23**	

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	sacrum, legs and buttocks ... Periodic Safety and Performance Checks: to ensure user safety, this product must be checked periodically for function and signs of wear. If the product does not function correctly or if significant wear is found in the buckles, mounting points, webbing, padding or stiches, stop using it ...." Although Resident 18 received weekly skin checks, the templated form did not include person-centered/individualized areas of inspection related to the use of her harness. Resident 18's comprehensive care plan lacked implementation/revision of a plan of care to routinely, and appropriately assess the need, appropriateness, installation, functioning and/or integrity of her positioning harness. The record lacked documentation of nursing staff education/in-serving for the placement, positioning, functioning and/or routine/ongoing monitoring/assessment of the device. During an interview on 11/2/23 at 10:43 a.m., the Director of Therapy indicated, Resident 18 was unable to put on or release her harness, and that she required staff to ensure it was placed properly. During an interview on 11/3/23 at 10:44 a.m., Resident 18 indicated, she was unable to put on or take off her positioning harness because of her multiple sclerosis. She indicated she relied ono nursing staff to put it on. The aides were the ones who "strapped" her in after they got her in her chair each day. Resident 18 indicated she assumed the staff had been educated on how to put it on properly and hoped that it was placed correctly each day.			

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	On 11/2/23 at 9:00 a.m., the DON provided a copy of current facility policy titled, "Assistive Devices and Equipment," dated 5/20/20. The policy indicated, "The Restoracy provides, maintains, trains and supervised the use of assistive devices and equipment for residents ... devices and equipment will be maintained on schedule and according to manufacturer's instructions. Defective or worn devices will be discarded or repaired. Staff will be required to demonstrate competency in the use of devices and equipment and be available to assist and supervise residents as needed ...." On 11/2/23 at 11:51 a.m., the Assistant DON (ADON) provided a copy of current, but undated facility policy titled, "Care Plans, Comprehensive Person-Centered." The policy indicated, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident ... The comprehensive, person-centered care plan will: include measurable objectives and timeframes, describe the services that are to be furnished ... care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making ...." 3.1-45			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic			

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	gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.			
	Based on observation, interview, and record review, the facility failed to ensure a resident's enteral tube feeding formulas and water containers were labeled according to policy for 1 of 1 resident reviewed for tube feeding (Resident 19). Findings include: On 10/30/23 at 10:03 a.m., Resident 19 was observed in bed, a tube feeding bag and water bag were observed hanging from an IV (intravenous) pole. Neither bag had labels and no hand writing was observed. The kangaroo pump indicated 40 milliliters (mL) per hour. On 10/30/23 at 2:26 p.m., Resident 19's tubing feeding formula and water bags had a information written on the bags in ink. It indicated 10/30/23, 12 a.m., with illegible initials.	F 0693	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Failed to label a resident's tube feeding with the rate, date, time and initials. **Corrective Action for resident(s) found to have deficient:** Resident 19 had her tube feeding	12/04/2023

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	On 10/31/23 at 9:13 a.m., the enteral feeding formula bag was labeled as Jevity 1.5, 10/30, 2100. The water bag was not labeled. On 10/31/23 at 9:47 a.m., Registered Nurse (RN) 8 indicated the enteral feeding formula and the water bag should always be labeled. On 11/1/23 at 9:27 a.m., Resident 19's record was reviewed. Her diagnoses included, but were not limited to, dementia, anxiety, severe protein calorie malnutrition, dysphagia (difficulty swallowing), hemiplegia (partial paralysis), aphasia (difficulty communicating), acute respiratory failure with hypoxia (limited oxygen reaching the tissues, and encephalopathy (function of the brain of affected). Her physician's orders indicated to change the feeding administration set (tubing) daily and label the formula container, syringe and administration set with resident's name, date, time, and nurse's initials on every night shift, starting on 9/28/2023. A nutrition care plan, dated 10/20/23, indicated Resident 19 had a potential or actual nutritional problem related to a history of requiring a g-tube to meet nutritional and hydration needs. Resident 19 had a history of "fair" by mouth intakes, dysphagia secondary to cerebral vascular accident (CVA), dementia, with severe protein calorie malnutrition. A Registered Dietitian (RD) progress note, dated 5/5/23, indicated Resident 19 was downgraded to a mechanical soft diet related to pocketing foods and for safety. She was assisted at meals per staff.		labeled with the rate, date, time and initials on 10/30/23. **Identify other residents having the same potential deficient:** Audit completed of in-house residents receiving tube feeding and no other residents use a tube feeding device. **Measures put into place or systemic changes:** The Director of Nursing, Assistant Director of Nursing or designee will provide education to the license nurses regarding appropriate and timely labeling a resident's tube feeding with the rate, date, time and initials. **Plan to monitor performance to maintain compliance:** The Director of Nursing, Assistant Director of Nursing or designee will perform an audit that appropriate and timely labeling a resident's tube feeding with the rate, date, time and initials was completed weekly x 4 weeks, then monthly x 5 months. If any compliance trends are identified, they will be reviewed in QAPI meetings. **Date of Compliance: 12/4/23**	

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	Resident 19 had a significant change on 6/4/23. She returned from a local hospital with a g-tube in place with an abdominal binder to help prevent her from pulling at it On 11/1/23 at 2:47 p.m., the Director of Nursing (DON) indicated an enteral feeding bag and the water should have been labeled with rate, date, time, and initials. She indicated item 2 on the policy, titled, "Enteral Feedings - Safety Precautions," was addressing the bags of enteral nutrition and water. A current policy, titled, "Enteral Feedings Safety Precautions," dated 5/20/20, was provided by the DON on 11/1/23 at 1:10 p.m. A review of the policy indicated, " ...On the formula label document initials, date and time the formula was hung, and initial that the label was checked against the order ...." 3.1-44(a)(2)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide			

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	services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview, and record review, the facility failed to ensure sufficient staff were available to answer and address the root cause needs/requests of residents without having to wait for long periods of time for 4 of 5 residents reviewed for call light response times (Residents 38, 18, 13 and 1). Findings include: 1. During a continuous observation on 10/30/23 from 4:00 p.m., until 4:55 p.m., the following was observed: At 4:00 p.m., Resident 38 was observed in bed. He indicated he wanted to get out of bed because he did not like to lay in bed for long periods of time. He was laid down after lunch around 1:30 p.m. and had put his call light on about "ten till 4:00, the girl came and said she would be right back," but he was still waiting. His call light was observed off at that time, and with his permission it was placed on again. Resident 38 indicated he often waited a long time to get up, because he needed two people and the Hoyer lift, plus when they were finally able to come, he would need to be cleaned up before he could be gotten out of bed.	F 0725	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. =”" spanadministrator="" has="" reviewed="" the="" staffing="" patterns,="" acuity="" levels,="" schedules="" ensure="" is="" appropriate="" each="" resident's <="" span="">=”" span="">"> **Alleged deficiency:** insufficient staff. **Corrective Action for resident(s) found to have deficient:** Resident 38, 13, 18, 1 have been assessed for any physical changes in condition and all	12/04/2023

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	At 4:13 p.m., certified nursing aide (CNA) 20 entered Resident 38's room and turned off his call light. He indicated he wanted to get up and she explained she needed to find someone else to help her get him up as he required the use of the Hoyer lift. At 4:21 p.m. the call light was pressed again. At 4:31 p.m., the Minimum Data Set Coordinator (MDSC) entered the room and indicated the CNAs were helping another resident but would be with him as soon as possible. She indicated, ideally, she would like a resident's needs/wants to be able to get up as soon as possible upon request but not have to wait longer than 10-15 minutes. At 4:34 p.m., CNA 20 and 21 entered the room with the Hoyer lift to get Resident 38 up. Before he could be transferred back into his chair the aids performed incontinent care. At 4:51 p.m., Resident 38 was positioned in his Hoyer sling in the bed and at 4:55 p.m., he was finally up and seated in his wheelchair. During an interview on 10/20/23 at 4:40 p.m., CNAs 20 and 21 indicated it was hard to get to everyone who needed help in a timely manner because each person that required the Hoyer needed both CNAs at the same time. Taking care of incontinent needs also added to other resident's wait times and even though there was a nurse or medication aid (QMA) they were often busy passing medications or doing treatments, or their other responsibilities too. During an interview on 10/30/23 at 5:01 p.m., the Director of Nursing (DON) indicated, there was		residents continue at their baseline. There have been no reported or observed deficiency in providing the highest practicable physical, mental and psychological well-being of these or other residents. No decline in their health or skin integrity related to waiting for care was neither reported nor observed. Care plans were reviewed regarding call-light use needs and all care plan expectations have been met. **Identify other residents having the same potential deficient:** All residents will be interviewed regarding call light wait times and any concerns will be reported to and addressed by the QAPI committee. The Facility Assessment tool was reviewed to ascertain adequate staffing levels for our population and our staffing levels continue to show that we have sufficient staffing levels. Our staffing logs from the weekends show that our ppd (per patient day) staffing levels remain the same as during the week. **Measures put into place or systemic changes:** The Director of Nursing, Assistant Director of Nursing or designee will provide education to the nursing staff regarding: 1 Staff to leave the call light on until the need is met to ensure that the staff come back to resolve	

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	not specific policy for call light response time, but her expectation was no one should wait longer than 15 minutes excluding emergency situations. Resident 38's call light response record was provided by the DON on 11/1/23 at 4:47 p.m. and reviewed at that time. The corresponding activation times for the above observation were as follows: On 10/30/23 he activated his call light at 3:49:42 p.m. The light was deactivated at 3:57 p.m. (8 min. 16 sec.) he activated the light a second time at 4:02:31 p.m. and was deactivated at 4:11:11 p.m. (8 min 40 sec.). The light was activated a third time at 4:21:49 p.m. and was deactivated 4:33:26 p.m. (11 min. 37 sec.). The average call light response time for these three activations was 9 minute and 31 seconds. However, from the initial activation at 3:49:42 p.m., until 4:33:26 p.m., a total of 44 minutes had surpassed. His call light device log was further reviewed to reveal the following (to include but was not limited to): a. On 10/25/23 he activated his call light at 10:16:03 p.m. It was deactivated at 10:25:41 p.m. (9 min. 38 sec.). He activated the light 3 minutes later at 10:28:51 p.m. It was deactivated at 10:28:54 p.m., (4 sec.) and activated for a third time at 10:28:55 p.m. and deactivated at 10:42:18 p.m. (13 min. 24 sec.). the average response time for these three activations was 7 min and 42 seconds. However, from the initial activation at 10:16:03 p.m. until 10:42:18 p.m., 26 minutes and 15 seconds had surpassed. b. On 10/18/23 between 8:58:38 p.m. until 11:14:02 p.m., he activated his call light 9 times. The average response time for those 9 activations was 10 minutes and 6 seconds. However, from the		the concern. 2 Staff to give residents anticipated times that they will return if they are answering their light but cannot stay to meet their immediate need. 3 Encourage C.N.As to ask the nurse or QMA to assist if needed if multiple call lights are on at the same time and residents need a 2-person assist. Administrator or designee will provide education to the residents that there may be some instances where care is slightly delayed with some residents needing care at the same time, but that staff will communicate a reasonable expectation for when their needs can be met. **Plan to monitor performance to maintain compliance:** The Director of Nursing, Assistant Director of Nursing or designee will perform an audit for resident satisfaction of call light wait times 3 times a week for 4 weeks, weekly for 8 weeks then monthly x 3 months. If any compliance trends are identified, they will reported to and addressed by the QAPI committee. We would like to IDR this citation in person to review our facility assessment and root cause analysis. Additionally, the Administrator has reviewed the staffing patterns, acuity levels, and	

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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
	initial activation at 8:58 p.m. until the final activation at 11:14 p.m., 2 hours and 16 minutes had surpassed. 2. On 10/31/23 at 11:10 a.m., Resident 13 was observed in his room seated in an electronic wheelchair. Resident 13 indicated he did not want to complain to get anyone in trouble, but he found that he did often wait a long time, mostly in the mornings before he was able to get up for the day. The aide usually wanted everyone to go to bed soon after dinner, and even though he did not want to go to sleep that early, he wanted to make things easier for the staff, so he agreed to lay down early and watch TV until he was ready for sleep. That just meant, but the time morning came, he was ready and anxious to get out of bed. He required two staff members and the Hoyer lift to get into his chair since he was not able to stand or walk. Resident 13 indicated when he put his light on they always came right away that was not the problem. But they would turn the light off, and sometimes forget to come back, or got caught up with someone else that needed them, so it took a long time to actually get out of bed. On 11/1/23 at 4:47 p.m., the DON provided copies of Resident 13's call light response log. a. On 10/6/23 he activated his Bath Device at 8:09:19 a.m. It was deactivated at 8:13:31 a.m. (4 min. 12 sec.) He activated it a second time 9:00:38 a.m. and it was deactivated at 9:01:35 a.m. (57 sec.) The average response time for those two activations was 2 minutes and 32 seconds. However, from the initial activation to the final deactivation, 52 minutes had surpassed. b. On 10/23/23 he activated his Bed Device at 7:00:35 a.m. It was deactivated at 7:02:22 a.m. (1 min. 47 sec.) He activated the light a second time at 7:35:48 a.m. and it was deactivated at 7:37:07		staffing schedules to ensure staffing is appropriate to ensure each resident's highest practicable physical, mental and psychological well-being. **Date of Compliance: 12/4/23** ="" b="">="" b="">	

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	155858	A. BUILDING 00 B. WING	11/03/2023

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	a.m. (1 min and 19 sec.) The average response time for these two activations was 1 minute and 33 seconds. However, from the initial activation at 7:00:35 a.m., until 7:37:07 a.m., approximately 36 minutes had surpassed. On 10/25/23 he activated his Bed Device at 7:27:28 a.m. It was deactivated at 7:36:18 a.m. He activated the light a second time at 8:00:05 a.m., and it was deactivated at 8:07:06 am. The average call light response time for these two activations were 7 minutes and 55 seconds. However, from 7:27 a.m. until 8:07 a.m., approximately 39 minutes had surpassed. 3. During an interview on 11/3/23 at 10:44 a.m., Resident 18 indicated she required the use of a Hoyer lift and two staff members to get up and get into her specialty wheelchair and get her positioning device placed. Staff were very responsive to answering the call lights, but they came in, turned it off and promised to come right back. Sometimes that happened, but most times it did not, especially on the weekends. She would need to put the light on a couple time for reminders until she was actually able to get what she needed. On 11/1/23 at 4:47 p.m., the DON provided copies of Resident 18's call light response log. a. On 10/2/23 she activated her Bath Device at 12:35:41 p.m., and it was deactivated at 12:36:24 p.m. (43 sec.) She activated the device a second time, two minutes later at 12:38:00 p.m. and it was deactivated at 12:41:11 p.m. (3 min. 11 sec.). She activated the device a third time at 12:56:13 p.m. and it was deactivated at 1:11:56 p.m. (15 min 43 seconds. The average response time for these three activations was 6 minutes and 35 seconds. However, from the initial activation at 12:35 p.m., until the final activation at 1:11 p.m., approximately			

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	36 minutes had surpassed. b. On 10/8/23 she activated her Bath Device at 1:02:59 p.m., and it was deactivated at 1:04:34 p.m., (1 min. 35 sec.) She activated it a second time at 1:19:22 p.m. and it was deactivated at 1:27:46 p.m. (8 min. 24 sec.). The average response time for these two activations was 3 minutes and 19 seconds. However, from the initial activation until the final activation, approximately 25 minutes had surpassed. 4. During an interview on 11/03/23 10:50 a.m., the Resident Council President, Resident 1, indicated she did not have an issues with call light wait times per say as she and the staff had a pretty good routine. However, on behalf of the Resident Council, call light wait times were often complained about, especially on the weekends when they often had agency staff cover shifts who were not familiar with the resident routines. Response to the resident council grievance was usually a printed report for the specific residents with concerns that showed their wait times were not actually that long. At that time, she gave permission to review the Resident Council Meeting Minutes for supportive documentation of call light response times. On 11/3/23 at 11:00 a.m., the Resident Council Meeting Minutes were reviewed and revealed the following: A Resident Council Grievance Form, dated 11/29/22, for a specific Resident who complained of call light response times. The action taken indicated, "...call light response times were pulled. Average time is 3 minutes and 34 seconds ...." The resident's corresponding call light device activity report was attached and reviewed: Bath Device:			

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	a. On 11/24/23, the call light was activated at 3:32:11 a.m., deactivated at 11:32:50 a.m. (39 sec.). It was activated a second time at 3:44:56 a.m., and deactivated at 3:45:28. For those two activations, the averaged call light response time was only 35 seconds. However, from the initial activation at 3:32:11 a.m., until the final deactivation at 3:45:28 a.m., a total of 13 minutes and 17 seconds had surpassed. b. On 11/24/23, the call light was activated at 12:23:37 p.m., and deactivated at 11:29:06 p.m. (5 min. 29 sec.). the light was activated a second time at 12:44:55 p.m. and deactivated at 12:54:27 p.m. (9 min and 32 sec.). for those two activations the average response time was 7 minutes and 30 seconds. However, from the initial activation at 12:23:37 p.m. until the final activation at 12:54:27 p.m., 30 minutes and 50 seconds had surpassed. c. On 11/25/23, the call light was activated at 3:33:25 p.m. and deactivated at 3:48:13 p.m. (14 min. 38 sec.) the light was immediately activated a second time at 3:48:13 p.m. and deactivated at 3:52:58 p.m. (4 min. 45 sec.). The light was activated a third time at 3:59:06 p.m., and deactivated at 4:00:19 p.m., (1 min 13 sec.) The average call light response time for these three activations was 6 min. and 52 seconds. However, from the initial activation at 3:33:35 p.m. until 4:00:19 p.m., 26 minutes and 44 seconds had surpassed. The Resident Council met on 7/28/23. Five Residents and 1 family representative were present. New Business Stated: "... a few complained that evening and weekend staff will come in and turn off the light and say, 'I will be right back' and a lot of the time they didn't come back ...." There was no documentation of actions taken to resolve the concern.			

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	The Resident Council met on 8/24/23. Four Residents attended. The Old/Resolved issues was left blank. New Business Stated: "...weekends are slower to answer lights ... still say 'I'll be right back' and didn't come back ...." There was no documentation of actions taken to resolve the concern. 5. Grievances logs were reviewed and revealed: A. An individual grievance form was filled out for a resident who complained of call light response times. The Grievance was dated 11/29/22. B. An individual grievance form was filled out for a resident who complained of call light response times. The Grievance was dated 7/21/23 at 9:00 a.m., Nature of Concern: "Resident complain call light response times in the evening." The Department Head review and action taken: "Call light times pulled. Longest call light time was 13 minutes during mealtime. Average call time is approximately 4 minutes. Educated resident of call light times. [The resident] requested new CNAs for evening. Educated resident that is not a feasible request ...Comments: Resident continued to request for new staff. Denies any poor customer service but does not want to wait when call light is pressed. Education provided to resident, stated understanding." The resident's corresponding call light device activity report was attached and reviewed: Bed Device: On 7/20/23 the call light was activated at 11:14:55 p.m., deactivated at 11:16:05 p.m. (1 min., 10 sec.) activated a second time at 11:22:06 p.m., deactivated at 11:22:15 p.m. (9 seconds), and activated a third time at 11:32:43 p.m., deactivated at 11:33:36 p.m. (53 seconds). For these three activations, the call light response time was 44			

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	seconds. However, from the initial activation at 11:14:44, until the final activation at 11:33:36, a total of 17 minutes and 41 seconds had surpassed. Bath Device: On 7/20/23 the call light was activated at 9:31:24 p.m., deactivated at 9:38:55 p.m. (7 min., 31 sec.), activated a second time at 9:53:05 p.m., and deactivated at 9:55:44 p.m. For these to activations, the call light response time was 5 min. 5 seconds. However, from the initial activation at 9:31:24 p.m. until the final deactivation at 9:55:44 p.m., a total of 24 minutes and 20 seconds had surpassed. During an interview on 11/3/23 at 11:13 a.m., with the Executive Director, DON, and ADON present, the call light response procedure was reviewed. The DON and ED indicated the facilities call light response times were far above industry standards, and while there was no disagreement about the average response time, root cause/tasks/requests/needs of the residents were that lights were being responded to but turned off and then often forgotten. The DON indicated when there were grievances related to call lights they could pull the report logs and compare the house cameras, however the cameras had been broken for several weeks and determining the root cause response times were impossible at that time. The ED indicated the response times proved staff were going into the rooms to turn the lights off and at least let the resident know where they were and how long to expect them to come back. There was no policy, but the DON and ED indicated it was preferable for residents not to wait longer than 15 minutes, or 30 maximum, emergencies excluded. 3.1-17(b)			

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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 observation, interview and record review, the facility failed to ensure a resident was not accidently given the wrong medication to prevent the potential for a significant medication error for 1 of 4 residents reviewed for accidents, (Resident 8). Findings include: On 10/30/23 at 11:14 a.m., Resident 8 was observed in her home's activity room. She was working on a table puzzle and agreed to an interview at that time. Resident 8 indicated she had never had a concern or issue until last week when she was mistakenly given another resident's medication. There had been an agency nurse on the weekend who must not have known the residents very well. That morning she had come to give Resident 8 her morning medication and after she had swallowed the cup of pills, she noticed the incorrect room number written on the cup. Resident 8 had received Resident 18's medications. Resident 8 indicated she used to live in the room where Resident 18 was now, and perhaps that was how the mix-up occurred. She did not remember much of the rest of the day, she felt dizzy and very tired and thought the medications must have interacted with whatever she regularly took. "That's my biggest fear, it frightens me to think what could have happened or if it might happen again. I never used to have to check my cups, but every cup of medicine I get now, I double and triple check it is the right room number."	F 0760	Past noncompliance: No POC required.	11/27/2023

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	On 11/1/23 at 9:27 a.m., Resident 8's medical record was reviewed. She was a long-term care resident with diagnose which included, but were not limited to, hypertensive heart (high blood pressure) and chronic kidney disease with heart failure, type II diabetes, major depressive disorder, and other seizures and narcolepsy without cataplexy. Resident 8's prescription medications were reviewed and revealed she received the following: Four medication with black-box warnings: a. sertraline: antidepressant medication b. diclofenac: a topical anti-inflammatory medication c. lisinopril: a high blood pressure medication d. Hydrocodone-acetaminophen: a narcotic pain medication Two controlled substances: a. Hydrocodone-acetaminophen b. armodafinil: a stimulant medication used to treat narcolepsy She also received 7 units of insulin daily, with 3 units before each meal for diabetes, a 10 milligram (mg) diuretic medication and additional blood pressure medications. Resident 18's prescription medications were reviewed and revealed she received the following: Six medications with black-box warning: a. hydrocodone-acetaminophen): a narcotic pain medication b. voltaren: a topical anti-inflammatory medication c. metformin: an anti-diabetic medication d. Trulicity: an anti-diabetic medication e. lisinopril			

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	f. bupropion: an anti-depressant medication Two controlled substances: a. the hydrocodone b. Lyrica: a nerve pain medication She also received additional anti-diabetic medications and blood pressure mediations. A Nurse Practitioner (NP) progress note dated 10/19/23 at 10:53 a.m., indicated Resident 8 had been seen by the NP for an acute visit for follow up related to the titration of her high blood pressure medication and heart failure. Her blood pressures that morning were within normal limits following the increase of her hydralazine, however, some high SBP (systolic blood pressure, the top number) with significant fluctuations of BP noted on chart review. An NP progress note dated effective on 10/20/23 at 10:56 a.m., but was recorded late on 10/25/23 at 10:56 a.m., indicated, Resident 8's SBP remained elevated with intermittent normal ranges and significant fluctuations. The hydralazine was increased to three times a day with blood pressure checks prior to each administration. A nursing progress note dated 10/21/23 at 12:33 p.m., indicated, Resident 8 was "inadvertently given medication that was not prescribed." The NP was notified, and her medications were reviewed. The NP gave instructions to monitor the resident and notify of adverse reactions. A nursing progress note dated 10/21/23 at 8:52 p.m., indicated, Resident 8 refused to take her evening medications as she stated that she did not want anything to happen to her. Her blood sugar, after her evening meal was 82, staff would			

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	continue to monitor for hyper/hypoglycemia. On 11/1/23 at 4:00 p.m., the Executive Director, (ED) provided a copy of the medication error investigation which had been conducted and was reviewed with no concern. Prior to the survey, staff were educated on safe medication administration procedures and a system was implemented to monitor for the deficient practice. Therefore, the deficient practice was corrected on 10/23/23, prior to the start of the survey, and was Past Noncompliance. 3.1-48(c)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of			

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	1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to date medications and destroy expired medications for 3 residents in 2 of 5 resident houses (Residents 44, 54, and 22). Findings include: 1. During an observation on 10/31/23 at 10:06 a.m., Resident 44 had a bottle of lorazepam 2mg/ml in house 5's refrigerator. The bottle was opened with no date to identify when it was opened. The pharmacy sent the bottle on 8/28/23. 2. During an observation on 10/31/23 at 10:08 a.m., Resident 54 had a bottle of lorazepam 2mg/ml in house 5's refrigerator. The bottle was illegible. His name was written on the bottle. There was no date to indicate when it was opened. 3. During an observation on 10/31/23 at 10:10 a.m., Resident 22 had a bottle of lorazepam 2mg/ml in house 5's refrigerator. The bottle was opened with no date to indicate when it was opened. The pharmacy sent the bottle on 3/13/23. 4. During an observation on 10/31/23 at 10:15 a.m., a vial of tuberculin serum was lying in the refrigerator of house 6 with no date to indicate when it was opened. During an interview with the DON (Director of Nursing) on 11/1/23 at 10:30 a.m., she indicated lorazepam was good for 30 days after opening. A policy titled, "Medication Storage Policy," with	F 0761	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Undated medications **Corrective Action for resident(s) found to have deficient:** Medications undated for residents 44, 54, 22, as well as the TB serum were discarded. **Identify other residents having the same potential deficient:** Audit completed of medications in nurses carts and fridges was conducted and no new medications were observed to be out of date. **Measures put into place or systemic changes:** The Director of Nursing, Assistant Director of Nursing or designee will provide education to the license nurses	12/04/2023

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	a date of 5/20/20 was provided by the DON on 11/1/23 at 11:05 a.m., it indicated, " ...Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock and disposed of according to policy from medication disposal ....". 3.1-25(j) 3.1-25(m) 3.1-25(n)		regarding: 1 Ensuring that all medications are reviewed for appropriate dates and throwing away any that are expired and have them replaced by the pharmacy. 2 Placing a date on all medications once they are opened. **Plan to monitor performance to maintain compliance:** The Director of Nursing, Assistant Director of Nursing or designee will perform an audit that stored medications are properly dated and will be completed weekly x 4 weeks, then monthly x 5 months. If any compliance trends are identified, they will be reviewed in QAPI meetings. **Date of Compliance: 12/4/23**	
F 9999 Bldg. 00	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in	F 9999	**Disclaimer:** This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is	12/04/2023

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	intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This state rule is not evidenced by: Based on record review and interview, the facility failed to ensure new employees received TB (Tuberculin Testing) timely for 5 of 10 employees reviewed for TB (CNA (Certified Nursing Assistants 13, 14, 15, 16) and Home Care Specialist 17). Findings include: On 11/2/23 at 10:00 a.m. employee records were reviewed. 1. CNA 13 was hired on 4/28/23. Her first step PPD (Purified Protein Derivative) was not initiated until 5/24/23. Her second step PPD was not		submitted to meet requirements established by the state and federal law. **Alleged deficiency:** Untimely TB Screens completed **Corrective Action for resident(s) found to have deficient:** Staff members 13, 14, 15, 16 and 17 have been appropriately screened for tuberculosis (TB). **Identify other residents having the same potential deficient:** Audit completed of all staff members and all staff have been appropriately screened for TB. **Measures put into place or systemic changes:** The Director of Nursing, Assistant Director of Nursing or designee will provide education to ADON that staff must receive appropriate TB screen on their first day of work or prior to starting their employment. **Plan to monitor performance to maintain compliance:** The Director of Nursing or designee will perform an audit that each new employee's TB screen was conducted timely and appropriately weekly x 4 weeks, then monthly x 5 months. If any compliance trends are identified, they will be reviewed in QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155858	A. BUILDING 00 B. WING	11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RESTORACY OF WHITESTOWN, THE	6712 RESTORACY DRIVE WHITESTOWN, IN 46075

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	completed until 5/31/23. 2. CNA 14 was hired on 3/23/23. His first step PPD was not initiated until 4/13/23. His second step PPD was not completed until 4/20/23. 3. CNA 15 was hired on 1/31/23. Her first step PPD was not initiated until 4/1/22. Her second step PPD was not completed until 4/10/22. 4. CNA 16 was hired on 2/15/23. Her first step PPD was not initiated until 8/1/23. Her second step PPD was not completed until 8/10/23. 5. Home Care Specialist 17 was hired on 8/1/23. His first step PPD was not initiated until 9/18/23. His second step was not completed until 9/27/23. During an interview with the ADON (Assistance Director of Nursing) on 11/2/23 at 12:10 p.m., she indicated the employee's start date was not the same as their orientation date. She indicated she has a plan to address the timeliness of PPDs. A policy titled "Tuberculosis, Screening Employees for," dated 5/20/20 was provided by the ADON on 11/2/23 at 1:13 p.m. It indicated, " ...New employees will be tested for LTBI (Latent Tuberculosis Infection) and active TB (Tuberculosis) disease up or before hire, utilizing the tuberculin skin testing ...."		**Date of Compliance: 12/4/23**	