STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE HANOVER	410 W LAGRANGE RD HANOVER, IN 47243

(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 and Investigation of Complaints IN00455300, IN00455842, and IN00455916.This vist included a State Residential Licensure Survey. Complaint IN00455300 - Federal/State deficiencies related to the allegations are cited at F584 and F925. Complaint IN00455842 - No deficiencies related to the allegations are cited. Complaint IN00455916 - Federal/State deficiencies related to the allegations are cited at F584 and F925. Survey dates: March 20, 21, 24, 25, 26, and 27, 2025 Facility number: 000115 Provider number: 155208 AIM number: 100291080 Census Bed Type: SNF/NF: 70 Residential: 4 Total: 74 Census Payor Type: Medicare: 1 Medicaid: 59 Other: 10 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jay Nowlin	Administrator	04/10/2025

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

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	Quality review completed on April 1, 2025.			
F 0577 SS=E Bldg. 00	483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info Based on observation and interview, the facility failed to have the State survey results available to view for 2 of 6 days during the survey. Findings include: During an observation, on 03/25/25 at 3:24 P.M., a laminated piece of paper on a corkboard outside the Administrator's office indicated the survey results were in a white binder in the living room. The living room and front entrance were observed, and no white binder or survey results were visible. During an observation, on 03/26/25 at 11:21 A.M., the living room and front entrance lacked visible survey results. During an observation, on 03/26/25 at 1:49 P.M., the living room and front entrance lacked visible survey results. During an interview, on 03/26/25 at 1:52 P.M., the Minimum Data Set (MDS) Coordinator indicated the State survey results were sitting in a pile in the Administrator's office and were not accessible for visitors to view without having to ask for them. They should be available for them to view without asking the staff. During an interview, on 03/27/25 at 10:02 A.M., the Administrator indicated the facility did not have a policy for State survey results being accessible to view, they would just follow the regulation.	F 0577	**F577 Right to Survey Results** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Survey Book is now on the table in the lobby for all to view. **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:**	04/10/2025

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	3.1-3(b)(1)		Admin, Director of Nursing, Assistant Director of Nursing educated by Vice president of operations on regulation requiring survey book availability **4) How the corrective actions will be monitored:** Administrator/Designee will check Survey book placement/availability weekly for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure Survey results binder is in place and available. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:** 04//10/15	
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment Based on observation, interview, and record review, the facility failed to provide a clean and safe environment related to a dirty shower room and safe walkways for 2 of 4 facility areas reviewed. (Wing 2 and the outside courtyard)	F 0584	**F584** **Safe/Clean/Comfortable/Home like environment**	04/10/2025

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	Findings include: 1. During an observation of Wing 2, on 03/21/25 through 03/25/25, the following concerns were observed on the following dates and times: - On 03/21/25 at 10:25 A.M., the Shower Room had sticky floors; a strong urine odor; the toilet base had a one inch by eight-inch band of black debris around toilet base; and a one-foot-long, a two-foot-long, and a three-foot-long stripe of black/brown residue around the tile areas in the shower stall. - On 03/21/25 at 10:33 A.M., the bathroom shared by Resident Rooms 23 and 24, had a baseball size shallow pit in the bathroom floor where tiles were missing. A resident in Room 23 was observed to be independent with toileting and unsteady on his feet. - On 03/24/25 at 10:26 A.M., the Shower Room had sticky floors; the toilet base had one inch by eight-inch band of black debris around toilet base; and a one-foot-long, a two-foot-long, and a three-foot-long stripe of black/brown residue around the tile areas in the shower stall. - On 03/24/25 at 3:17 P.M., the bathroom shared by Resident Rooms 27 and 28, had a strong urine odor. - On 03/25/25 at 10:23 A.M., the bathroom shared by Resident Rooms 23 and 24, had a baseball size shallow pit in the bathroom floor where tiles were missing. - On 03/25/25 at 10:25 A.M., Resident Room 18's bathroom door had brown stains and chunks of		*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident B is being taken to an alternate area to smoke. Bids obtained for repair of concrete The Shower room in wing 2 has been deep cleaned and pressure washed. Quotes obtained to renovate the bathroom replacing walls and floors. Bathroom floor shared by room 23 and 24 has been replaced. Bathroom shared by room 27 and 28 has been deep cleaned. Resident room 18 bathroom door has been cleaned. Wing two floors have been deep cleaned, Pest Control called in to treat gnats on unit 2. . Maintenance request forms audited 100 percent to make sure	

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	brown debris on the doorknob to the bathroom. During an interview, on 03/27/25 at 10:25 A.M., Licensed Practical Nurse (LPN) 7 indicated there was a resident who resided in Room 23 who was able to use the bathroom without staffs' assistance. During an anonymous interview, from 03/20/25 through 03/27/25, a staff member indicated a group of volunteers had complained, while on Wing 2, the floors were filthy with food particles; spilled fluid;, and a swarm of gnats. A volunteer even started cleaning the floor because the spills were so bad. The nursing staff would not clean anything up, they left it for Housekeeping. "Wing 2 was always a mess." During an interview, on 03/27/25 at 10:12 A.M., the Housekeeping Supervisor indicated they had cleaning check-off lists for each unit. Staff were to check off items after they were completed. They also had a separate check off list for deep cleaning. On a deep clean they pulled everything out of the residents' room, cleaned the walls, the privacy curtain, the bedding, pulled out the beds, cleaned the bed frame, window blinds, the trim, and the bathrooms. Rooms were deep cleaned every couple of weeks and as needed. Some were done more often. She kept the deep clean check off lists. She kept the daily check-off lists for about two weeks. Blank checklists were provided by the Housekeeping Supervisor. She indicated she did not have any completed checklists for any of the units since she had just thrown them away. None of the checklists included cleaning the walls of the shower rooms. During an interview, on 03/27/25 at 2:48 P.M., when asked for the building inspections for the		all requests completed. **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. All residents are going to an alternate area for smoking. All residents rooms and commons areas inspected for cleanliness and cleaned or repaired if needed. **3) Measures put into place/ System changes:** Staff have been educated that residents will be taken to alternate smoking area until repairs are made. Outdoor patio will be closed for use until repairs are completed. Housekeepers educated on use of checklist, deep cleans and shower room cleaning. Maintenance educated on inspection sheet and policy. Housekeeping to keep binder with checklists in office. Maintenance to keep rounding sheets in a binder in office according to policy. **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of check off sheets, observations of Wing 2 to ensure cleanliness, and maintenance inspection sheets for (3 times a week for)?4 weeks then (3 times a	

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	interior and exterior of the building, the Maintenance Director indicated he walked through the building everyday but did not document his observations. 2. During an observation, on 03/27/25 at 11:11 A.M., Resident B was outside in the courtyard in his wheelchair with a group of residents that were awaiting to smoke. While propelling himself, he fell forward, with the wheelchair still attached to his back because he used a seat belt for positioning and landed face down with his forehead touching the sidewalk. Another resident turned the resident to his side as no staff were within five feet of this resident. During an interview, on 03/27/25 at 1:26 P.M., CNA 8 indicated they had put in a work order for the concrete chipping. No one was with the resident when he fell. They had put the work order in about two weeks ago because they noticed it was getting worse, and all the rain had not helped. The resident had a scrape on his forehead and a little bump on the back of his head from today's fall. The Progress Notes for Resident B were provided by the DON on 03/27/25 at 3:14 P.M. A note, dated 03/27/25 at 11:00 A.M., indicated the resident had an unwitnessed fall in the courtyard smoking area. The resident's wheelchair tipped over as he was propelling it on the concrete. The resident's statement indicated, "I was coming to smoke and the chair tipped over because of the concrete." The resident received a scrape to the forehead and a small bump on the top of his head. The "MAINTENANCE REQUEST" forms were provided by the Administrator on 03/27/25 at 1:50 P.M. A request, from CNA 9, dated 03/12/25,		week?) every other week for 8 weeks then monthly times 3 months to ensure all sheets and inspections are being done. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	indicating the sidewalk had a "big chunk" out of it, and could you please look at it and see if something could be done. The current undated "Housekeeping Service Policy" was provided by the Corporate Clinical Nurse Consultant on 03/27/25 at 1:45 P.M. The policy indicated, "...Purpose...To ensure that the facility, equipment, furnishings [sic] and resident rooms are maintained in a sanitary manner; to provide a comfortable environment, and to prevent the development and transmission of infection...maintain a clean, odor free,...orderly environment...which meet...the...residents right for a safe, clean, comfortable homelike environment..." The current undated "Preventative Maintenance and Inspections" policy was provided by the DON on 03/27/25 at 2:40 P.M. The policy indicated, "...Inspection checklists are developed for at least...The building...Exterior inspection will be conducted and documented weekly...Interior inspection will be conducted and documented weekly...Condition of flooring...Cement cracks...Each resident room will be inspected and documented monthly..." The current "Falls" policy, with a reviewed date of 01/01/15, was provided by the DON on 03/27/25 at 2:40 P.M. The policy indicated, "...Licensed nurse should conduct assessment immediately, including events leading up to the fall to determine when possible and causative factors..." This citation relates to Complaints IN00455300 and IN00455916. 3.1-19(a)(4) 3.1-19(f)(5)			

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F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to administer prescribed medications related to insulin administration for 1 of 19 residents reviewed for Quality of Care. (Resident 12) Findings include: The clinical record for Resident 12 was reviewed on 03/27/25 at 10:45 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 02/07/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, diabetes, hypertension, dementia, and paranoid schizophrenia. The January 2025 Electronic Medication Administration Record/Electronic Treatment Administration Record (EMAR/ETAR) was provided by the Director of Nursing (DON) on 03/27/25 at 11:37 A.M. The physician's order, with a start date of 11/13/24 and a discontinued date of 01/14/25, indicated the resident was to receive Humalog (insulin) 12 units, to be administered after meals. The January 2025 Electronic Medication Administration Record/Electronic Treatment Administration Record (EMAR/ETAR) for Resident 12 indicated the resident's Humalog was scheduled for 9:00 A.M., 1:00 P.M., and 7:00 P.M. The record lacked documentation (was left blank) the resident received the prescribed insulin on the following dates and times: January 3, at 7:00 P.M., January 4, at 7:00 P.M., and January 5, at 7:00 P.M.	F 0684	**F- 684 Quality of care** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. **What corrective actions have been accomplished for those residents found to have been affected by the deficient practice.** Resident 12 assessed with no negative outcome. Licensed nursing staff educated on proper documentation of administration per order, and refusal and notification of refusal to MD as per policy **How the facility will identify other residents having the potential to be affected by the same alleged deficient practice:** All residents receiving prescribed medications related insulin administration have the potential to be affected by the deficient practice.	04/10/2025

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	The resident's Blood Glucose Fingerstick Monitoring record was reviewed and indication the following: on January 3, at 7:00 P.M., the resident blood sugar value was 390; on January 4, at 7:00 P.M., the resident's blood sugar value was 143; and on January 5, at 7:00 P.M., the resident's blood sugar value was 280. The Progress Notes for January 2025 were provided by the DON on 03/27/25 at 11:37 A.M. The record lacked documentation as to why the medication was not given. The current Diabetes Care Plan, with an initiated date of 08/27/24, indicated the staff were to administer the resident's diabetes medication as ordered by the doctor. During an interview, on 03/26/25 at 1:33 P.M., RN 6 indicated if a resident refused a medication or procedure, staff were to mark it as refused on the EMAR/ETAR and they also documented in the Progress Notes. The EMAR ETAR should not have blanks on it. The current, undated, facility policy titled, "Medication Administration General Guidelines", was provided by the MDS Coordinator on 03/27/25 at 1:15 P.M. The policy indicated, "...Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so...If a dose of regularly scheduled medications is withheld, refused, not available, or given at a time other than the scheduled time...An explanatory note is entered...If 3 consecutive doses of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response..."		**Measures the facility will take to ensure that the problem will be corrected and will not recur:** All nursing staff educated on proper documentation of administration per order, and refusal and notification of refusal to MD as per policy **Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:** Administrator/ DON and or designee will perform Medical Record Reviews with appropriate documentation and MD notification three times a week for four weeks then weekly times eight weeks to ensure these Physician Orders have been followed. The results of the above audits will be reviewed in the Quality Assurance Meeting monthly until 100% compliance is achieved for three consecutive months. The QAA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Any discrepancies will be reported to the QAA Committee with recommendations and education provided as needed	

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F 0692 SS=D Bldg. 00	3.1-37(a) 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review and interview, the facility failed to monitor meal consumption's and have supplements available for 1 of 3 residents reviewed for nutrition. (Resident 43) Findings include: 1a. The clinical record for Resident 43 was reviewed on 03/25/25 at 11:46 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 01/20/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, Huntington's disease, anemia, seizure disorder, anxiety, depression, and abnormal weight loss. The Meal Consumption Record for the resident lacked documented meals for the following dates and times: - On 01/02/25 at dinner, - On 01/07/25 at dinner, - On 01/11/25 at dinner, - On 01/16/25 at dinner, - On 01/23/25 at dinner, - On 01/28/25 at dinner, - On 02/01/25 at dinner, - On 02/05/25 at dinner, - On 02/09/25 at dinner, - On 02/11/25 at dinner, - On 02/13/25 at dinner, - On 02/17/25 at dinner, - On 02/20/25 at dinner, - On 02/27/25 at dinner,	F 0692	**F692 Nutrition/Hydration Status Maintenance** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. ***1) What corrective actions have been accomplished for those residents found to have been affected by the deficient practice?*** Resident 43 assessed with no negative outcome. CNA's educated on proper documentation of meal consumption. Mighty shakes in stock, house supplements to be offered if not available. ***2) How will the facility identify other residents having the potential to be affected by the same deficient practice?*** All residents have the potential to be affected by the same alleged deficiency.	04/10/2025

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	- On 03/03/25 at dinner, - On 03/09/25 at dinner, - On 03/11/25 at dinner, - On 03/18/25 at dinner, and - On 03/22/25 at dinner. During an interview, on 03/27/25 at 1:24 P.M., Certified Nurse Aide (CNA) 8 indicated the resident's meal consumptions were to be documented on the electronic computer system after each meal. If the resident refused the meal there was a place in the computer system for them to document that. The current facility policy titled, "Caregiver Documentation" with a revision date of 01/15/18, was provided by the Clinical Corporate Nurse Consultant on 03/27/25 at 2:29 P.M. The policy indicated, "...To establish a system for providing and documenting appropriate care provided to the resident at the CNA/caregiver level...The CNA/Caregivers will document resident's care in electronic medical record according to their assignment and tasks completed as assigned...in accordance with the CNA's/caregiver's training and resident's plan of care...The CNA will complete all required documentation for each resident under their care assignment before clocking out at the end of the shift..." 1b. A current open-ended physician's order, with a start date of 04/28/22, indicated the resident was to receive a mighty shake (supplement) with meals. The March 2025 Electronic Medication Administration Record (EMAR) indicated the resident had not received the mighty shake on the following dates and times:		***3) The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not re-cur:*** CNA's educated on proper documentation of meal consumption. Mighty shakes to be kept in stock with house supplements to be offered if not available. **4) How the corrective actions will be monitored:** DON will complete daily medical record review for 4 weeks then weekly review every other week for 8 weeks then monthly times 3 months to ensure all sheets and inspections are being done. The results of the above audits will be reviewed in the Quality Assurance Meeting monthly until 100% compliance is achieved for 3 consecutive months. The QAA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. . The Administrator will monitor completion of the Quality Assurance monitoring.	

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	- On 03/02/25 at 12:00 P.M. and 5:00 P.M., - On 03/06/25 at 12:00 P.M. and 5:00 P.M., - On 03/10/25 at 12:00 P.M. and 5:00 P.M., and - On 03/11/25 at 7:00 A.M., 12:00 P.M., and 5:00 P.M. The Progress Notes were reviewed and indicated the mighty shakes were unavailable for the dates and times with the resident had not received it. During an interview, on 03/26/25 at 1:47 P.M., Licensed Practical Nurse (Licensed Practical Nurse) 7 indicated if they were out of mighty shakes, she would give the resident an alternate supplement and document it. The facility had never been out of mighty shakes that she was aware of. The current, undated, facility policy titled, "Medication Administration General Guidelines", was provided by the MDS Coordinator on 03/27/25 at 1:15 P.M. The policy indicated, "...Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so..." 3.1-46(a)(1)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure a medication was available for 1 of 19 residents reviewed for pharmacy services. (Resident 56) Findings include: The clinical record for Resident 56 was reviewed	F 0755	**F755 Pharmacy Svc/Procedures/Pharmacists/Records** *This Plan of Correction is the center's credible allegation of compliance.*	04/10/2025

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	155208	A. BUILDING 00 B. WING	03/27/2025

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	on 03/27/25 at 1:44 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 12/10/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, Huntington's disease, chorea (neurological disorder that causes involuntary muscle movements), hypertension, and depression. A physician's order, dated 09/13/24 through 09/25/24, indicated the resident was to receive Austedo (a medication for chorea) 18 milligrams (mg), twice a day. The September 2024 Electronic Medication Administration Record (EMAR) indicated the resident had not received the medication on the following dates and times: - On 09/20/24 at bedtime, - On 09/21/24 at bedtime, - On 09/22/24 at bedtime, and - On 09/23/24 at bedtime. A physician's order, dated 10/19/24 through 11/13/24, indicated the resident was to receive Austedo XR (extended release) 18 mg, once a day for Huntington's disease. The October and November 2024 EMAR indicated the resident had not received the medication from 10/20/24 through 11/2/24. The Progress Notes indicated the following: - On 09/20/24 the medication was not available from the pharmacy to administer, - On 09/21/24 they were waiting on the medication to arrive from the pharmacy, - On 09/22/24 the medication was not available		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 56 now receives medications as per Physicians orders. Resident 56 assessed with no negative outcome **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Licensed Nursing staff have been educated on contacting Pharmacy & MD if medication not available in the back up Medication Bank. **4) How the corrective actions will be monitored:**	

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	from the pharmacy to administer, - On 09/23/24 the medication was pending arrival from the pharmacy, - On 10/20/24 the medication was not available, - On 10/23/24 the medication was not available, - On 10/24/24 the medication was not available, - On 10/25/24 the medication was not available, - On 10/26/24 the medication was not available, - On 10/27/24 the medication was not available, - On 10/28/24 the medication was not available, - On 10/29/24 the medication was not available, - On 10/30/24 the medication was not available, and the Nurse Practitioner was notified, - On 10/31/24 the medication was not available, - On 11/01/24 the medication was not available, and - On 11/02/24 the medication was not available. The resident's clinical record lacked documentation that the physician or pharmacy was notified or contacted related to the medication being unavailable. During an interview, on 03/27/25 at 10:25 A.M., Licensed Practical Nurse (LPN) 7 indicated if a resident didn't have a medication available to give in the medication cart, she would check the facilities emergency drug kit to see if she could get it from there. If it was not available in the kit, she would contact the pharmacy to see about getting it sent from the back-up pharmacy. If the medication was still unavailable to get, she would contact the physician. She would document in a progress note that the physician and pharmacy was notified. The current, undated, facility policy titled, "Medication Administration General Guidelines", was provided by the MDS Coordinator on 03/27/25 at 1:15 P.M. The policy indicated,		DON/Designee will complete 5 Medical record reviews a week for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure medication is available and administered and /or appropriate action is taken if unavailable. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	"...Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so...If a dose of regularly scheduled medications is withheld, refused, not available, or given at a time other than the scheduled time...An explanatory note is entered...If 3 consecutive doses of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response..." 3.1-25(a)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On Based on interview and record review, the facility failed to address pharmacy recommendations for 3 of 5 residents reviewed for medication irregularities. (Residents 37, 32, and 4) Findings include: 1. The clinical record for Resident 37 was reviewed on 03/26/25 at 2:25 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 01/29/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, stroke, diabetes, irritable bowel syndrome, anxiety, and depression. The pharmacist reviewed the resident's medications monthly and made the following recommendations: - A Consultant Pharmacist Recommendation to Prescriber, dated 12/20/24, indicated the resident's current physician's orders included an order for Loperamide (an anti-diarrheal medication) liquid	F 0756	**F756 Drug Regimen Review, report Irregular, Act on** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	04/10/2025

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	solution, 1 mg (milligrams) per 7.5 (milliliter) mL. The resident was to receive 30 mL (4 mg) every twelve hours as needed and the resident had a current order for Loperamide oral capsules, 2 mg every 4 hours as needed. It was recommended that the prescriber review the continued use of the duplicate orders. - A Consultant Pharmacy Recommendation to Nursing, dated 12/20/24, indicated the resident had a current physician's order for Topamax (an anticonvulsant medication that was also used to treat migraine headaches and bipolar disorder) for depression. Depression was not an appropriate diagnosis for the use of the medication. It was recommended that the order be updated with an appropriate supportive diagnosis and to contact the prescriber for clarification. - A Consultant Pharmacist Recommendation to Prescriber, dated 01/20/25, indicated the resident received Duloxetine (an antidepressant) 30 mg daily since 07/19/24. It was recommended to consider a trial dose reduction of the medication. If a gradual dose reduction was contraindicated, the provider was to document the clinical rationale. The resident's clinical record lacked any indication the physician responded to the pharmacist's recommendations. During an interview, on 03/26/25 at 2:07 P.M., the Director of Nursing (DON) indicated the pharmacist reviewed the residents' medications monthly. She received the recommendations via email and ensured follow through. There was usually a response from the provider within a week, if not sooner. There should be documentation to indicate whether the physician		All recommendations for resident 4, 32 and 37 have been reviewed and updated. Resident 4, 32 and 37 have been assessed with no negative outcome noted. **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** DON/ADON and Social services director educated on GDR policy. Licensed Nursing staff have been educated on Pharmacy recommendations policy **4) How the corrective actions will be monitored:** DON/Designee will complete 5 Medical record reviews a week for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure antibiotic medication is available and administered and /or appropriate action is taken if unavailable. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of**	

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	agreed or didn't agree with the recommendation and the rationale. 2. The clinical record for Resident 32 was reviewed on 03/25/25 at 9:22 A.M. A Quarterly MDS assessment, dated 02/05/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, anemia, Alzheimer's disease, cerebral palsy, dementia, seizure disorder, depression, and bipolar. A Pharmacy Recommendation, dated 12/20/24, indicated to add a 14 day stop date to the residents Lorazepam (an anxiety medication) that was given as needed. The current physician's order, with a start date of 10/22/24, indicated the resident was to be given Lorazepam 1 mg every 4 hours as needed for anxiety. The clinical record lacked indication the physician was made aware of the recommendation. During an interview, on 03/26/25 at 2:35 P.M., the DON indicated the pharmacy review from 12/20/24 was not reviewed or acknowledged. 3. The clinical record for Resident 4 was reviewed on 03/26/25 at 3:08 P.M. An Annual MDS assessment, dated 03/06/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, Parkinson's disease, hypertension, diabetes, dementia, anxiety, and psychotic disorder. The pharmacist reviewed the resident's medications monthly and made the following recommendations:		**100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	- A Consultant Pharmacist Recommendation to Prescriber, dated 12/20/24, indicated the resident currently received Mirtazapine (antianxiety) 15 mg every night, Sertraline (antidepressant) 50 mg every night, and Trazadone (antidepressant) 50 mg every night. A trial dose reduction was recommended. There was no indication the physician or prescriber responded to the pharmacist's recommendation. During an interview, on 03/27/25 at 10:25 A.M., the DON indicated she did not see anything in the resident's clinical record that addressed the pharmacy recommendation. The current facility policy, titled Psychotropic Medication-Gradual Dose Reduction, revised on 02/01/18, was provided by the DON on 03/26/25 at 2:47 P.M. The policy indicated, "...The pharmacist will report any irregularities to the Director of Nursing. The Director of Nursing will notify or direct licensed staff to notify attending physician as necessary..." 3.1-25(i)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to store medications appropriately for 1 of 2 medication storage rooms (Wing 2 Medication Storage Room) and 3 of 4 medication carts observed (Wing 2 Medication Cart and Wing 3 Medication Carts). Findings include:	F 0761	**F761 Label/Store Drugs and Biologicals** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of*	04/10/2025

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	During an observation, on 03/21/25 at 10:16 A.M., the Wing 2 Medication Storage Room had three unopened bags of g-tube feeding formula that were not in a box that were sitting on the bare floor and six unopened boxes sitting on the bare floor. The Director of Nursing (DON) indicated the boxes were supplies. During an observation, on 03/21/25 at 10:19 A.M., a Wing 2 Medication Cart contained a loose round tan pill inside a drawer. Licensed Practical Nurse (LPN) 7 removed the pill and disposed of it at that time. During an observation and interview, on 03/21/25 at 10:43 A.M., a Wing 3 Medication Cart contained the following loose pills inside the drawers: - a white round pill, LPN 10 indicated it was a Tylenol, - an oval pill, LPN 10 indicated was a coenzyme, - a small white pill, LPN 10 indicated was risperidone, and - a small yellow/tan colored pill, LPN indicated was baclofen. LPN 10 removed all the loose pills from the cart and placed them in a medication cup. During an observation and interview, on 03/21/25 at 10:48 A.M., a Wing 3 Medication Cart contained a loose white round pill, lots of small papers, and what appeared to powdered pill substances in all the corners of the drawers, LPN 3 indicated the loose pill was a trazodone, the nurses were responsible for cleaning out the medication carts, that cart was pretty dirty. She would clean it out that day.		*this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** No residents were affected by this alleged deficient practice. Medications for Wing 2 and Wing 3 now properly stored. **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Licensed Nursing staff educated on storage of medications policy **4) How the corrective actions will be monitored:** DON/Designee will inspect med rooms and carts daily for 4 weeks then every other week for 8 weeks then monthly times 3	

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	The current, undated, facility policy titled, "Medication Storage" was provided by the Administrator on 03/27/25 at 10:02 A.M. The policy indicated, "...Medications and biologicals are stored safely, securely, and properly, following the manufacturer's recommendations or those of the supplier...Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity..." 3.1-25(o)		months to ensure Medication storage policy being followed **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to follow appropriate guidelines related to the use of hairnets in the kitchen for 3 of 3 kitchen observations. (Dietary Manager, Cooks 4 and 5, and the Corporate Dietary Consultant) Findings include: 1. During a tour of the kitchen, on 03/20/25 at 11:01 A.M., the Dietary Manager (DM) had three inches of hair outside of her hairnet on each side and the back of her head while she was in the food preparation area. During an observation, on 03/26/25 at 11:54 A.M., the DM had three inches of hair exposed outside the hairnet while in the food preparation area. During a kitchen observation, on 03/27/25 at 11:42 A.M., Cook 4 had six inches of hair exposed outside her hairnet on the right side of her face, Cook 5 had two inches of hair exposed outside the	F 0812	**F812 Food Procurement, Store/Prepare/Serve Sanitary** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. **1)What corrective actions have been accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice Dietary staff now wearing hairnets	04/10/2025

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	hairnet around her face, the DM had three inches of hair exposed outside the hairnet on both sides of face and on the back of her neck, and the Corporate Dietary Consultant had three inches of bangs and two inches of hair exposed outside the hairnet on both sides of her face while in the food preparation area. During an interview, on 03/27/25 at 11:56 A.M., the DM indicated hairnets should cover all the hair. If hair cannot be contained with one hair net, two hairnets should be used. The current "Hair Restraints" policy, dated 2020, was provided by the Director of Nursing on 03/27/25 at 3:15 P.M. The policy indicated, "...Staff shall wear hair restraints in all food production, dishwashing, and serving areas." 3.1-21(i)(3)		as per policy. **2)How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected by the same deficiency. **3)The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not re-cur:** Dietary Staff have been educated on complete and through wearing of Hairnets. **4) How the corrective actions will be monitored:** Administrator/Designee will perform 5 observations a week for 12 weeks to ensure through wearing of Hairnets. The results of the above audits will be reviewed in the Quality Assurance Meeting monthly until 100% compliance is achieved for 3 consecutive months. The QAA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. . The Administrator will monitor completion of the Quality	

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to follow infection control guidelines related to enhanced barrier precautions for 3 of 3 wound care observations. (Residents 75, 4, and 31) Findings include: 1. The clinical record for Resident 75 was reviewed on 03/24/25 at 11:34 A.M. An Admission Minimum Data Set (MDS) assessment, dated 01/27/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, Parkinson's disease, metastasized bone cancer, hypertension, dementia, and chronic obstructive pulmonary disease. An open-ended physician's order, with a start date of 03/18/25, indicated the resident was in enhanced barrier precautions (for a chronic wound. During an observation, on 03/26/25 at 11:22 A.M., the resident's door had a sign on it that indicated to STOP that they were in enhanced barrier precautions. Everyone must wear gloves and a gown when providing wound care. Licensed Practical Nurse (LPN) 2 entered the resident's room and provided wound treatment care without donning a gown. 2. The clinical record for Resident 4 was reviewed on 03/26/25 at 3:08 P.M. An Annual MDS assessment, dated 03/06/25, indicated the resident	F 0880	Assurance monitoring. **F880 Infection Prevention and Control** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 75, 4 and 31 assessed with no negative outcomes from alleged deficient practice. Enhanced Barrier Precautions being followed per policy. **2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice.	04/10/2025

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	was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, Parkinson's disease, hypertension, diabetes, dementia, anxiety, and psychotic disorder. An open-ended physician's order, with a start date of 12/27/24, indicated the resident was in enhanced barrier precautions for a chronic wound. During an observation, on 03/26/25 at 11:46 A.M., the resident's door had a sign on it that indicated to STOP that they were in enhanced barrier precautions. Everyone must wear gloves and a gown when providing wound care. LPN 2 entered the resident's room and provided wound treatment care without donning a gown. During an interview, on 03/26/25 at 3:17 P.M., LPN 3 indicated gloves and a gown should be worn during a wound dressing change if the resident was on enhanced barrier precautions. 3. The clinical record for Resident 31 was reviewed on 03/25/25 at 9:46 A.M. A Quarterly MDS assessment, dated 12/26/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, dementia, diabetes, non-Alzheimer dementia, anxiety, depression, and psychotic disorder. An open-ended physician's order, with a start date of 01/29/25, indicated the resident was in enhanced barrier precautions (to reduce the risk of transmitting multidrug-resistant organisms [MDRO] and targeted MDRO when contact precautions do not apply for residents identified at higher risk) for a chronic wound. During an observation, on 03/26/25 at 3:17 P.M.,		**3) Measures put into place/ System changes:** Nursing staff have been reeducated on the Facilitys' -Enhanced Barrier Precuations care for residents on EBP. **4) How the corrective actions will be monitored:** DON/Designee will complete 5 observations of ADL care for residents who are on EBP week for 4 weeks then 5 observations every other week for 8 weeks then 5 observations of ADL care including catheter care, peri care, treatments, glucose monitoring a month for 3 months to verify compliance. **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	155208	A. BUILDING 00 B. WING	03/27/2025

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	the resident's door had a sign on it that indicated to STOP that they were in enhanced barrier precautions. Everyone must wear gloves and a gown when providing wound care. RN 6 entered the resident's room and provided wound treatment care without donning a gown. The current facility policy titled, "Enhanced Barrier Precautions" with a revision date of 05/07/24, was provided by the Corporate Clinical Nurse Support on 03/27/25 at 2:07 P.M. The policy indicated, "...To reduce the risk of transmitting multidrug-resistant organisms [MDRO] and targeted MDRO when contact precautions do not apply for residents identified at higher risk...EBP are used in conjunction with standard precautions and expand to use of PPE [Personal Protective Equipment] to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing...Wounds generally include chronic wounds..." 3.1-18(b)			
F 0925 SS=F Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program Based on observation, record review, and interview, the facility failed to ensure an effective pest control was in place for residents' bathrooms and bedrooms related to gnats or drain flies. This deficient practice had the potential to affect 70 of 70 residents that resided in the facility. Findings include: During an observation of Wing 2, on 03/21/25 through 03/25/25, the following concerns were observed on the following dates and times:	F 0925	**F925 Maintains Effective Pest control program** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the*	04/10/2025

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	- On 03/21/25 at 10:25 A.M., the Wing 2 Shower Room had sticky floors; a strong urine odor; the toilet base had one inch by eight-inch band of black debris around toilet base; and a one-foot-long, a two-foot-long, and a three-foot-long stripe of black/brown residue around the tile areas in the shower stall. - On 03/21/25 at 10:33 A.M., the bathroom shared by Resident Rooms 23 and 24, had a swarm of gnats flying about the room and multiple gnats on the walls. - On 03/21/25 at 10:39 A.M., the bathroom shared by Resident Rooms 25 and 26, had several gnats flying about the room. Resident D indicated they have had a problem with gnats for a while. - On 03/24/25 at 10:24 A.M., the Resident Room 26, had a few gnats flying about in the residents' bedroom. - On 03/24/25 at 3:17 P.M., the bathroom shared by Resident Rooms 27 and 28, had several gnats flying about the residents' bedroom area. Resident E indicated they have had a problem with gnats in their room and bathroom for a while. - On 03/24/25 at 10:24 A.M., in the Resident Room 26, had a few gnats flying about in the residents' bedroom. - On 03/24/25 at 3:17 P.M., the bathroom shared by Resident Rooms 27 and 28 had several gnats flying about the residents' bedroom. Resident E indicated they have had a problem with gnats in their room and bathroom for a while. - On 03/25/25 at 10:14 A.M., the bathroom shared		*facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident B is being taken to an alternate area to smoke. Quotes obtained for repair of concrete The Shower room in wing 2 has been deep cleaned and pressure washed. Quotes obtained to renovate the bathroom replacing walls and floors. Bathroom floor shared by room 23 and 24 has been replaced. Bathroom shared by room 27 and 28 has been deep cleaned. Resident room 18 bathroom door has been cleaned. Wing two floors have been deep cleaned, Pest Control called in to treat gnats on unit 2. (Scheduled routinely) Maintenance request forms audited 100 percent to make sure all requests completed. **2) How the facility identified other residents:**	

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	by Resident Rooms 27 and 28 had several gnats flying about the room and on the walls. - On 03/25/25 at 10:23 A.M., the bathroom shared by Resident Rooms 23 and 24 had several gnats flying about the room and on the walls. - On 03/25/25 at 10:30 A.M., on the walls in the hallways of Wing 2 there were several gnats observed on the walls. During an interview, on 03/27/25 at 10:11 A.M., the Maintenance Director indicated the facility had a Pest Control provider who came into the facility every two weeks. The pest control provider did not normally go into the residents' bedrooms or bathrooms. During an interview, on 03/27/25 at 10:12 A.M., the Housekeeping Supervisor indicated they had cleaning check-off lists for each unit. Staff were to check off items after they were completed. They also had a separate check off list for deep cleaning. On a deep clean they pulled everything out of the residents' room, cleaned the walls, the privacy curtain, the bedding, pulled out the beds, cleaned the bed frame, window blinds, the trim, and the bathrooms. Rooms were deep cleaned every couple of weeks and as needed. Some were done more often. She kept the deep clean check off lists. She kept the daily check-off lists for about 2 weeks. Blank checklists were provided by the Housekeeping Supervisor. She indicated she had just thrown them away and did not have any completed checklists for any of the units. None of the checklists included cleaning the walls of the shower rooms. The Pest Control visit records for the last 3 months were provided by the Maintenance		All residents have the potential to be affected by the alleged deficient practice. All residents are going to an alternate area for smoking. All residents' rooms and commons areas inspected for cleanliness and cleaned or repaired if needed. **3) Measures put into place/ System changes:** All Staff have been educated that residents will be taken to alternate smoking area until repairs are made. Outdoor patio will be closed for use until repairs are completed. All housekeepers educated on use of checklist, deep cleans and shower room cleaning. Maintenance educated on inspection sheet and policy. Housekeeping to keep binder with checklists in office. Maintenance to keep rounding sheets in a binder in office according to policy. **4) How the corrective actions will be monitored:** Admin/Designee will complete daily audit of check off sheets and maintenance inspection sheets for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure all sheets and inspections are being done. **The results of these audits will be reviewed in Quality**	

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	Director on 03/27/25 at 11:50 A.M. Only one record, dated 03/18/25, included a service documented as "One Shot". During an interview on 03/27/25 at 2:48 P.M., when asked for the building inspections for the interior and exterior of the building, the Maintenance Director indicated he walked through the building everyday but did not document his observations. During an interview on 03/27/25 at 2:50 P.M., the facility's pest control company indicated "One Shot" was their internal code for just a one-time service. They had used a product in the drains that would make it less hospitable for gnats and drain flies. They came out twice a month for routine services. They applied a general application for pests in the common areas and in the kitchen for preemptive maintenance and did not treat the residents' bathrooms or bedrooms. For the product they had put in the drains, they really did not have a time frame as to when the situation may alleviate itself because of other factors. 2. During an observation on 03/27/25 at 11:11 A.M., Resident B was outside in the courtyard in his wheelchair with a group of residents that were awaiting to smoke. While propelling himself, he fell forward, with the wheelchair still attached to his back because he used a seat belt for positioning and landed face down with his forehead touching the sidewalk. Another resident turned the resident to his side as no staff were within five feet of this resident. During an interview on 03/27/25 at 1:26 P.M., CNA 8 indicated they had put in a work order for the concrete chipping. No one was with the resident		**Assurance Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	when he fell. They had put the work order in about two weeks ago because they noticed it was getting worse, and all the rain had not helped. The resident had a scrape on his forehead and a little bump on the back of his head from today's fall. The Progress Notes for Resident B were provided by the DON on 03/27/25 at 3:14 P.M. A note, dated 03/27/25 at 11:00 A.M., indicated the resident had an unwitnessed fall in the courtyard smoking area. The resident's wheelchair tipped over as he was propelling it on the concrete. The resident's statement indicated, "I was coming to smoke and the chair tipped over because of the concrete." The resident received a scrape to the forehead and a small bump on the top of his head. The "MAINTENANCE REQUEST" forms were provided by the Administrator on 03/27/25 at 1:50 P.M., and included, but was not limited to, the following: - A request, from CNA 9, dated 03/12/25, indicating the sidewalk had a "big chunk" out of it, and could you please look at it and see if something could be done. The current undated "Housekeeping Service Policy" was provided by the Corporate Clinical Nurse Consultant on 03/27/25 at 1:45 P.M. The policy indicated, "...Purpose...To ensure that the facility, equipment, furnishings [sic] and resident rooms are maintained in a sanitary manner; to provide a comfortable environment, and to prevent the development and transmission of infection...maintain a clean, odor free,...orderly environment...which meet...the...residents right for a safe, clean, comfortable homelike environment..."			

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	The current undated "Preventative Maintenance and Inspections" policy was provided by the DON on 03/27/25 at 2:40 P.M. The policy indicated, "...Inspection checklists are developed for at least...The building...Exterior inspection will be conducted and documented weekly...Interior inspection will be conducted and documented weekly...Condition of flooring...Cement cracks...Each resident room will be inspected and documented monthly..." The current "Falls" policy, with a reviewed date of 01/01/15, was provided by the DON on 03/27/25 at 2:40 P.M. The policy indicated, "...Licensed nurse should conduct assessment immediately, including events leading up to the fall to determine when possible and causative factors..." This citation relates to Complaints IN00455300 and IN00455916. 3.1-19(f)(4)			
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 Nursing Home Complaints IN00455300, IN00455842, and IN00455916. Complaint IN00455300 - Federal/State deficiencies related to the allegations are cited at F584 and F925. Complaint IN00455842 - No deficiencies related to the allegations are cited. Complaint IN00455916 - Federal/State deficiencies	R 0000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of*	

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	related to the allegations are cited at F584 and F925. Survey dates: March 20, 21, 24, 25, 26, and 27, 2025 Facility number: 000115 Residential Census: 4 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 1, 2025.		*federal and state law*	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure residents' Service Plans were reviewed in a timely manner for 2 of 7 residents reviewed for Evaluation of Needs. (Residents 2 and 9) Findings include: 1. The clinical record for Resident 2 was reviewed on 03/27/25 at 10:00 A.M. The resident's diagnoses included, but were not limited to, heart failure and hypertension. The resident's Service Plan in the Electronic Health Record (EHR) was initiated on 04/16/21 and most recently reviewed on 03/21/24, after the resident experienced a fall. 2. The clinical record for Resident 9 was reviewed on 03/27/25 at 10:15 A.M. The resident's diagnoses included, but were not limited to, diabetes and schizophrenia. The resident received a Medicaid Waiver. The resident's Service Plan in the EHR was initiated on 03/04/24. The next	R 0214	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident 2 and 9 have updated service plans	04/10/2025

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	scheduled review date was 06/04/24. There was no indication the Service Plan had been reviewed. During an interview, on 03/27/25 at 10:40 A.M., the Director of Nursing (DON) indicated it was the responsibility of the nurse that provided care for the resident or the DON to update the residents' Service Plans according to the facility policy. The current, undated facility policy titled "Evaluation of Resident's Needs" was provided by the DON on 03/27/25 at 10:38 A.M. The policy indicated, "...An evaluation of the Resident's needs will be completed at admission and at least every six (6) months thereafter...A service plan will be developed based on the evaluation and will be reviewed at a minimum of every six (6) months and updated as needed; Medicaid Waiver residents will have Service Plan updated at least every three (3) months..."		**2) How the facility identified other residents:** All residents have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** Licensed nursing staff educated on completion of service plans as required **4) How the corrective actions will be monitored:** DONDesignee will check 2 service plans weekly for 4 weeks then every other week for 8 weeks then monthly times 3 months to ensure service plans are updated as required **The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100 % compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:** 04//10/2025	