STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN 46552

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: April 29, 30, & May 1, 2, 3, & 6, 2024 Facility number: 000427 Provider number: 155672 AIM number: 100275150 Census Bed Type: SNF/NF: 52 Residential: 28 Total: 80 Census Payor Type: Medicare: 1 Medicaid: 46 Other: 5 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/9/24.	F 0000	This Plan of Correction constitutes my 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 state and federal law.	
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and			

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

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	psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			

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	Based on observation, record review, and interview, the facility failed to develop person-centered care plans for activities, behaviors, ADLs (activities of daily living), and dementia care for 4 of 15 residents whose care plans were reviewed. (Residents 25, 23, 36 and 53) Findings include: 1. During a random observation on 4/30/2024 at 11:21 A.M., Resident 25 was not seen in an activity. During an observation, on 4/30/2024 at 1:19 P.M., Resident 25 was in bed sleeping, there was a small clock radio sitting on a dresser across the room, there was no television in the room. A record review was completed on 5/1/2024 at 2:22 P.M. for Resident 25. Her diagnoses included, but were not limited to, dementia, anxiety, depression, psychotic disorder and bipolar. An Annual MDS (Minimum Data Set) assessment, dated 5/31/2023, indicated it was not very important to her to have books, magazines, newspapers to read and it was somewhat important to listen to music she liked. A Quarterly MDS assessment, dated 2/18/2024, indicated the resident had a severe cognitive impairment, and had had delusions and physical behaviors. She received antipsychotics, antidepressants and anti-anxiety medications. A current Care Plan, dated 2/7/2024, indicated the resident preferred the comfort of her room to that of attending group activities. She tended to refuse groups when invited. She liked to watch TV, have family visits and work word puzzles. She was a	F 0656	The facility is alleged to be out of compliance by failing to develop and implement a personalized care plan for 4 of 15 residents whose care plans were reviewed. (Residents 25, 23, 36, and 53). A Careplans for residents 25, 23, 36, and 53 were reviewed updated, and personalized. B Careplans were reviewed for all other residents regarding activities, behaviors, ADLs and dementia care. C Nursing staff were educated by MDS on personalization of care plans and care plan revisions. D An audit will be completed by MDS/designee for residents for personalized care plans/care plan revisions three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	06/07/2024

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	florist. The goal was for the resident to be active with activity of choice in her room daily i.e.: TV, reading, talking on the phone, attend a group out on the unit i.e.: flower arranging occasionally at her leisure thru next review. Interventions included, but were not limited to, provide reading material, puzzle books, assist with TV or phone and radio PRN (as needed), and provide 1-1 interactions PRN. The activity log sheets dated for March and April indicated the resident had attended 10 activities in all. During an interview, on 5/6/2024 at 2:30 P.M., the Activity Director indicated the care plan was not person-centered and did not have interventions that would work for the resident. A Nurses' Note, dated 2/9/2024, indicated the resident kept yelling intermittently through out the night. She kept saying "Dad! Mom! Bob! Help me!" When staff went to her room and asked what she needed, she said "I need to get into my car and go home". Staff diverted the resident's attention by providing fluids and some cookies as requested, but she still would go back to the habit of yelling after a few minutes. A Nurses' Note, dated 2/14/2024, indicated the resident was attempting to get out of bed, looking for "Mother and Daddy." The resident was brought out to the nurses' station, given cookies and a pop. She continued to yell out "help, mother and daddy". The resident became angry with staff, thinking they were holding her back. A Nurses' Note, dated 2/15/2024, indicated Resident 25 was yelling and trying to get out of			

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	bed prior to breakfast. She was brought out to the common area for breakfast. She only ate bites, but took her medications. She continued to talk out loud to call her father and attempted to stand up from her wheelchair. The resident has had 3 pops and cookies, and was brought off the unit for a walk. Back in the common area, she was wanting staff to call her father with repetitive requests. A Nurses' Note, dated 3/21/2024, indicated the "resident was up all night, alert and very confused. Resident kept yelling 'Please come in and save the dogs! They are in front of me!' Resident then started yelling 'Why are the cats here!', reassurance in a calm manner provided." A Nurses' Note, dated 4/11/2024, indicated the resident intermittently asked repetitive questions at breakfast. She believed her mother was coming to get her. A current Care Plan, dated 3/28/2023, indicated the resident had the potential for Impaired Psychosocial well-being related to loss of interest in doing things and preferred the comfort of her room and bed. Interventions included, but were not limited to, encourage and invite to activities, and facilitate development of peer relationships/participate in activities. A current Care Plan, dated 2/27/23, indicated the resident had an alteration in behavior as evidence by repetitive calling out related to diagnoses of dementia, Bipolar Disorder, and Pseudobulbar affect. Interventions included, but were not limited to: 1) Call Resident by preferred name. 2) Identify self and explain all procedures and reason before performing. 3) Keep communication simple, yes/no questions. Allow time for resident to process and respond. 4) Speak clearly and			

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	distinctly in a calm, re-assuring voice. 5) Always approach her calmly and in an unhurried manner. 6) Administer medication as ordered. 7) Attempt to redirect disruptive behavior to something positive when she is exhibiting inappropriate behavior. 8) Provide cognitive cues/reminders/redirection as needed. Resident 25 is calling out for [name of daughter] reorient her that daughter is not present and Resident is at [name of facility]. Reassure her that staff will send daughter down to her room when she visits, weekly. 9) Notify physician/ N.P. to any sudden, acute changes in resident's usual cognitive/mood/behavioral functioning levels for further follow up as indicated. 10) Alert nurse to any observations and/or expressions of pain/discomfort. 11) Alert nurse to any unmet ADL (activities of daily living) for follow up. 12) Encourage frequent family visits. 13) Praise resident when in a positive mood state and she uses her call light to summon staff. 14) Involve in low stress activities to keep occupied. 15) Provide expressions of comfort, emotional support and reassurance as needed. Encourage to discuss feelings. 16) Monitor interaction with peers and/or visitors in Common Area. Redirect away if inappropriate behavior is exhibited. 17) Offer in-between meal snacks as indicated. Keep daughter's cookie snacks in zip lock bags that resident is able to open close to her. 18) Keep call cord within residents reach. Re-orient and demonstrate usage as needed. During an interview, on 5/03/2024 at 10:42 A.M., the ADON indicated the care plans were not person-centered for the resident's specific behaviors.2. On 5/1/2024, at 1:41 P.M., a record review was completed for Resident 23. Diagnoses included, but were not limited to: dementia with behavior disturbance, major depressive disorder,			

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	psychotic disorder with delusions, and anxiety. A Care Plan, initiated on 12/12/2023, indicated Resident 23 demonstrated an altered level of cognitive function as evidenced by a Brief Interview of Mental Status (BIMS) score of 11, indicating moderate impairment. Interventions included to call the resident by preferred name with each interaction to reinforce name recognition, introduce yourself and explain what you are doing in plain simple terms, keep the routine and caregiver as consistent as possible, present one idea, question, or command at a time, ask yes or no questions, break tasks into one step at a time, and provide cues and reminders as needed. During an interview, on 5/3/2024, at 2:27 P.M., the Infection Prevention Nurse indicated the resident's care plan for dementia was not person centered regarding interventions.3. During an observation, on 4/29/2024 at 11:11 A.M., Resident 36 was noted to not have been shaved and his fingernails were long with brownish yellow matter under them. A record review for Resident 36 was conducted on 5/01/2024 2:18 P.M. Diagnoses included, but were not limited to, Alzheimer's, dementia, major depressive disorder, general anxiety disorder, and psychotic disorder with delusions. An Annual Minimum Data (MDS) assessment, dated 2/1/2024, indicated no response to the question regarding cognition. No behavior concerns were noted. He was dependent for bathing, hygiene, and dressing. He needed set up help for bed mobility, transfers and walking. A Care Plan indicated Resident 36 had an actual or			

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	potential problem with activities of daily living (ADLs) secondary to impaired cognition, decreased mobility, incontinence, generalized weakness and medication use. Interventions included, but were not limited to, explain all procedures. The care plan lacked documentation that the resident sometimes refused shaving and trimming or cleaning fingernails. During an interview, on 5/3/2024 at 11:05 A.M., the ADON indicated there should have been a care plan for Resident 36 refusing ADLs.4. Resident 53's record review was completed, on 5/1/2024 at 9:16 A.M. Her diagnoses included, but were not limited to: dementia, Alzheimer's Disease and heart disease. A Quarterly MDS (Minimum Data Set) assessment, dated 2/6/2024, indicated Resident 11 had severe cognitive impairment. A Care Plan, dated 8/17/2023, indicated Resident 53 had cognitive loss related to short and long term memory loss, severely impaired cognitive skills and abilities. Interventions included, but were not limited to: ask yes or no questions; encourage and invite to activities to keep occupied; anticipate and meet needs. During an interview, on 5/03/24 at 3:06 P.M., the Assistant Director of Nursing indicated Resident 53's Care Plan was not person centered regarding interventions. On 5/3/2024 at 1:47 P.M., the Director of Nursing provided a policy, dated 1/29/2024, and titled, "Comprehensive Care Plans". The Director of Nursing indicated it was the policy currently used			

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	by the facility. The policy indicated, "It is the policy of this campus to develop and implement a comprehensive person-centered care plan for each resident... "Person-centered care" means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives...." 3.1-35(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observations, record reviews, and interviews, the facility failed to provide activities of daily living (ADLs) for 1 of 4 residents reviewed for activities of daily living. (Resident 36) Finding includes: During an observation, on 4/29/2024 at 11:11 A.M., Resident 36 was noted to not have been shaved and his fingernails were long with brownish yellow matter under them. During an observation on 5/1/2024 at 9:10 A.M., Resident 36 was still not shaved and his fingernails were long. A record review for Resident 36 was conducted on 5/1/2024 2:18 P.M. Diagnoses included, but were not limited to, Alzheimer's, dementia, major depressive disorder, general anxiety disorder, and psychotic disorder with delusions.	F 0677	The facility was alleged to be out of compliance by failing to provide assistance for the removal of facial hair and nail care for 1 out 1 resident. (Resident 36) A Resident #36 was provided assistance with the removal of facial hair and nail care was provided. Care plan updated to include refusal of care. B Residents were assessed for facial hair and nail care and care planned for assistance. C Nursing staff were educated on ADL care to include removal of facial hair, provision of nail care. Nursing staff was also educated on documentation and notification of refusal of care. D An audit will be completed by Social Service/designee for three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4	06/07/2024

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	An Annual Minimum Data (MDS) assessment, dated 2/1/2024, indicated no response to the question regarding cognition. No behavior concerns were noted. He was dependent for bathing, hygiene, and dressing. He needed set up help for bed mobility, transfers and walking A Care Plan indicated Resident 36 had an actual or potential problem with activities of daily living (ADLs) secondary to impaired cognition, decreased mobility, incontinence, generalized weakness and medication use. Interventions included, but were not limited to, explain all procedures. The care plan lacked documentation that the resident sometimes refused shaving and trimming or cleaning fingernails. During an interview, on 5/1/2024 at 1:49 P.M., CNA 2 indicated showers and morning ADL care included shaving and nail care if needed. Resident 36 often refused shaving and nail care. On 5/3/2024, an aide report sheet did not indicate that Resident 36 refused ADL care at times or what to do if he refused. During an interview, on 5/3/2024 at 11:05 A.M., the ADON indicated there was no care plan for Resident 36 refusing ADLs and the aide should report to the nurse if a resident refused and the nurse would document in interdisciplinary (ID) notes. When a resident refused care, the aide should see if another staff member would be able to complete the care. On 5/3/2024 at 2:05 P.M., the ADON provided a current policy titled, "Activities of Daily Living" and dated 1/23/2024. The policy indicated, "...Care and services will be provided for the following activities of daily living: Bathing, dressing,		weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	

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	grooming and oral care...." 3.1-38(a)(3)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to provide activities that support the physical, mental, and psychosocial well-being of each resident for 3 of 4 residents reviewed for activities. (36, 25, and 53) Findings include: 1. During an observation, on 4/29/2024 at 11:09 A.M., Resident 36 was sitting in the Center Unit common area with his back to the TV. There were no activities taking place. During a continuous observation, on 5/1/2024 from 9:16 AM to 11:22 AM, Resident 36 was sleeping on couch in the Center Unit common area. He woke up about 11:20 and is just sitting on couch. During a continuous observation, on 5/2/2024 from 9:28 A.M. to 11:11 A.M., Resident 36 was sitting in a wheelchair in the Center Unit common	F 0679	The facility is alleged to be out of compliance by failing to provide meaningful, personalized activities for 3 of the 4 residents reviewed for activities. (Residents 36, 25, and 53). A Personalized activities were provided, and care planned for residents 36, 25, and 53. Resident 36 was reassessed for activities and preferences. The care plan was updated to reflect the current status and was added to the 1-1 visits with sensory stimuli. Resident 25 was reassessed for activities and preferences. The care plan was updated to reflect the current status and added to 1-1 visits. Resident 53 was reassessed for activities and preferences. The care plan was updated to reflect	06/21/2024

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	area. His head was dropped down to his chest and his eyes were closed. No activity taking place on unit at this time. During a continuous observation on 5/3/2024, the following occurred: At 9:04 A.M., Resident 36 was sitting in the Center Unit common area when the activity aide announced that she would be back later to play a game. At 9:36 A.M., the activity aide again announced she will be back soon to play a game. At 10:32 A.M., the resident was still sitting in the Center Unit common area and no game or other activity was taking place. The TV was on but he was not interested. 3 other residents in the area are not engaged in any activity and one was asleep on the couch. At 11:03 A.M. the Activity Aide gathered various residents to play a game on the West Unit. Resident 36 was not included and remained on the Center Unit. A record review for Resident 36 was conducted on 5/1/2024 2:18 P.M. An Annual Minimum Data (MDS) assessment, dated 2/1/2024, indicated no response to the question regarding cognition. No behavior concerns were noted. Activity preferences included it was somewhat important to listen to music and very important to get fresh air. Diagnoses included, but were not limited to, Alzheimer's, dementia, major depressive disorder, general anxiety disorder, and psychotic disorder with delusions. Physician orders included, but were not limited to: 2/25/2024 Seroquel 25 (milligram) mg tablet by mouth every evening for psychotic disorder with delusions. 2/11/2021 Zoloft 100 mg tablet with 25mg tablet (to		the current status and added to 1-1 visits with sensory stimuli. Rummage materials were also supplied to the unit. B Residents were reviewed for activity preferences. Attendance logs were reviewed for possible candidates for 1-1 program. The 1-1 program was updated with residents that would benefit from 1-1 visits. C Activities staff were educated by the Activities Director regarding personalized activities for all residents, 1-1 documentation, and visits. AD to audit attendance logs monthly to observe for changes in residents' preferences and attendance. D An audit will be completed by Activities/designee for residents requiring 1:1 activities & preferences and make revisions as necessary three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	

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	total 125 mg) by mouth every day for major depressive disorder. A care plan problem indicated Resident 36 needed escorts to and from groups and assistance to turn on the TV to watch sports or musicals. His goal was to be included in groups, allowed to sit in the common area watching the daily life of the unit, and to participate in 1:1 interactions when presented. Interventions included, but were not limited to, he prefers sports on TV such as golf, staff will provide assist with transport to and from activities, and provide him with sports magazines and National Geographic, as requested. Documentation of 1:1 activities indicated that Resident 36 received 1:1 activities 2-3 times a week during March and April 2024. During an interview on 5/03/2024 at 1:21 P.M., the Activity Director indicated she did training with Resident Care Aides and Certified Nursing Assistants today on sensory stimulation for residents. Transporting dementia residents to the activity was sometimes an issue. There needed to be more activities on the Center unit.2. During an observation, on 4/30/2024 at 11:21 A.M., Resident 25 was observed in her room sleeping. During an observation, on 4/30/2024 at 1:19 P.M., Resident 25 was in bed sleeping. A record review was completed on 5/1/2024 at 2:22 P.M. Resident 25's diagnose included, but were not limited to heart failure, dementia, seizures, anxiety, depression, psychotic disorder and bipolar. A Quarterly MDS (Minimum Data Set) Assessment, dated 2/18/2024, indicated the			

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	resident had a severe cognitive impairment. Had delusions and physical behaviors and received antipsychotics, antidepressants and antianxiety medications. A current Care Plan, dated 2/7/2024, indicated the resident preferred the comfort of her room to that of attending group activities. She tended to refuse groups when invited. She liked to watch TV, have family visits and work word puzzles. She was a florists. Goal: the resident will be active with activity of choice in her room daily i.e.: TV, reading, talking on the phone. Attend a group out on the unit i.e.: flower arranging occasionally at her leisure thru next review. Interventions included, but were not limited to, provide reading material, puzzle books, other supplies for independent activity such as silk flowers. Assist with TV, phone and radio PRN (as needed). Respect the right to refuse. Encourage socialization with peers for psychosocial wellbeing. Provide 1-1 interactions PRN, and observe for changes. An April activity calendar indicated, on 4/30/2024, the activities for the day were: 10:00 A.M. exercise, 2:00 P.M. craft and 6:00 P.M. movie. Resident 25 was not documented as attending the craft activity at 2:00 P.M. The March and April activity participation calendars indicated the resident had attended 10 activities. During an interview, on 5/6/2024 at 2:30 P.M., the Activity Director indicated the care plans were not person centered and did not have interventions that would work for the resident. 3. During an observation on 4/29/24 from 10:00 A.M. until 11:58 A.M., Resident 53 was observed sitting at table			

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	with two other female residents. She was not talking with anyone and was either fidgeting with her hands or resting her head on her hands. During an observation on 4/30/24 at 10:53 A.M. Resident 53 was sitting on the East Unit in front of the television, but no sound was on. Resident 53's record review was completed on 5/1/2024 at 9:16 A.M. Her diagnoses included, but were not limited to: dementia, Alzheimer's Disease and heart disease. A Quarterly MDS (Minimum Data Set) assessment, dated 2/6/2024, indicated Resident 11 had severe cognitive impairment and had unclear speech. She could only understand others and make herself understood some of the time. A Care Plan, dated 8/17/2023, indicated Resident 53 had cognitive loss related to short and long term memory loss, severely impaired cognitive skills and abilities. Interventions included, but were not limited to: ask yes or no questions; encourage and invite to activities to keep occupied; anticipate and meet needs. Resident 53's record lacked the documentation she had refused participation in activities and she did not have an Activities Care Plan. Resident 53's March 2024 Activities Log indicated she had participated in activities on the following dates: 3/4/2024, 3/5/2024, 3/8/2024, 3/13/2024, 3/18/2024, 3/20/2024, 3/26/2024 and 3/29/2024. Resident 53's April 2024 Activities Log indicated she had participated in activities on the following dates: 4/10/2024, 4/11/2024, 4/12/2024, 4/16/2024, 4/26/2024 and 4/29/2024.			

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	During an observation on 5/01/2024 at 9:40 A.M., Resident 53 was seen walking around East Unit. She went into room 1130 and walked back out immediately. Resident 53 walked off the unit and was observed walking around Center Unit. The resident walked back to East Unit and sat in a recliner when staff offered her food. On 5/01/2024 at 10:05 A.M., a group activity, "Drum on Ball", was observed. Resident 53 was not in activity. During an interview on 5/3/2024 at 9:54 A.M., CNA 9 indicated he did not invite Resident 53 to activities. Instead, he would get several of the residents who don't participate in activities and have them sit at a table together and encourage the residents to converse with each other. During an interview on 5/03/2024 at 10:12 A.M. RN 10 indicated she did not invite Resident 53 to activities. RN 10 spent one on one time with the resident singing as an activity. RN 10 indicated one on one with the resident didn't happen often but it did happen on Sundays when RN 10 had more time. During an interview on 5/3/2024 at 1:22 P.M., the Activities Director indicated the facility typically has two activities a day, except on the weekends. One to one activities are provided for residents who don't participate in group activities and the facility did not have a process to document when a resident is invited to an activity but refuses. She indicated Resident 53 did not get invited to all the activities and did not participate in many activities for the month of March and April. On 5/3/2024 at 1:45 P.M., the Activities Director			

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	provided a policy, dated 9/30/2020, and titled, "Activities". The Activities Director indicated the policy was the current policy used by the facility. The policy indicated, "...Facility-sponsored group and individual activities and independent activities will be designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, as well as, encourage both independence and interaction within the community...." 3.1-33(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to secure a resident's cigarettes at the Nurse's Station for 1 of 1 resident who was reviewed for smoking. (Resident 11) Finding includes: During an observation on 4/29/24 at 11:37 A.M., Resident 11 had a long silver tray with an ashtray containing ashes, two cigarette butts, two cigarettes and a pack of opened cigarettes on a table in his room. Resident 11 had an empty ashtray sitting on his bedside table. Resident 11's record review was completed on	F 0689	The facility is alleged to be out of compliance by failing to ensure that a resident's environment remains as free of accident hazards as is possible by not securing a resident's cigarettes at the Nurses Station for 1 of 1 resident who reviewed for smoking. (Resident 11) A Cigarettes were removed from residents room and placed and Nurses Station. B Residents, who smoke, were identified, care plans reviewed to ensure cigarettes are not at	06/07/2024

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	5/1/24 2:33 P.M. His diagnoses included, but were not limited to: cerebral infarction, hemiplegia following cerebral infarct, generalized anxiety, chronic atrial fibril, edema, anemia, chronic pain, arthritis, vascular dementia, type 2 diabetes. A Quarterly MDS (Minimum Data Set) assessment, dated 4/2/2024, indicated Resident 11 had intact cognition. A Care Plan, dated 2/8/2024, indicated Resident 11 had alteration in behavior as evidence by selling cigarettes to Assisted Living Residents. Interventions included, but were not limited to: if resident continued to curse at staff or sell cigarettes to Assisted Living Residents, ask his sister to speak to her brother; cigarettes, matches and lighters to be kept at nurses station; and assure any cigarettes were extinguished before coming back indoors. A Care Plan, dated 2/13/2024, indicated Resident 11 had potential for complications or injury related to smoking cigarettes. Interventions included, but were not limited to: educate resident and family/visitors as needed on smoking regulations; remind resident and family/visitors this is a smoke free facility; assist resident into courtyard when resident wants to smoke; make sure resident is dressed appropriately for the weather; make sure that any cigarettes are properly disposed of when resident comes indoors. During a random observation on 5/2/2024 at 2:04 P.M., Housekeeper 7 went into Resident 11's room and came out with a pack of cigarettes and took the resident outside to smoke. On 5/2/2024 at 2:25 P.M., an interview with Resident 11 was completed. He indicated he was a		bedside. Residents who smoke and families were educated on smoking policy. C Nursing staff were educated by the DON on Smoking Policy. D An audit will be completed by Activities/designee for resident who smoke. Three times a week for 4 weeks, twice a week for 4 weeks, once weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	

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	supervised smoker and was not allowed to have cigarettes in his room. During the interview, Resident 11 had a long silver tray with an ashtray containing ashes and two cigarette butts. Resident 11 had an empty ashtray sitting on his bedside table and a pack of cigarettes on his shelf. During an interview on 5/3/2024 at 10:04 A.M., CNA 9 indicated cigarettes were kept at the Nurse's Station and Resident 11 should not have cigarettes, cigarette butts or ash trays in his room. An interview with Housekeeper 7 was completed on 5/3/2024 at 10:07 A.M. Housekeeper 7 indicated she was Resident 11's sister and had taken him out to smoke the previous afternoon. She did not know if his cigarettes should be in his room or not. During an interview on 5/3/2024 at 10:20 A.M., RN 10 indicated Resident 11 should not have cigarettes in his room. An interview with the Director of Nursing (DON) was completed on 5/3/2024 at 1:15 P.M. The DON indicated Resident 11 should not have smoking materials in his room and the cigarettes had been removed. On 5/3/2024 at 1:47 P.M., the DON provided a policy, dated 9/2021, and titled, "Smoking Policy." The DON indicated it was the policy currently used by the facility. The policy indicated, "... 14. All smoking materials will be maintained by activities staff during the day and nursing staff after 5 PM and on weekends. Resident and family members will turn smoking materials in after completion of smoking...." 3.1-45(a)			

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F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on interview, record review, and observation, the facility failed to prevent a resident with dementia from wandering into other residents' rooms for 1 of 3 residents reviewed for dementia care. (Resident 53) Finding includes: During an interview on 4/30/2024 at 10:05 A.M., Resident 49 indicated Resident 53 came into his room often and sometimes she would take his belongings. He always got his belongings back. During an interview on 4/30/2024 at 2:30 P.M., Resident 40 indicated Resident 53 was confused and came into her room and took her things. Staff knew and kept the door closed, but Resident 53 still entered. Resident 40 indicated she always got her belongings back, but felt it frustrating to have the other resident in her room sometimes. Resident 53's record review was completed on 5/1/2024 at 9:16 A.M. Her diagnoses included, but were not limited to: dementia, Alzheimer's Disease and heart disease. A Quarterly Minimum Data Set (MDS) assessment, dated 2/6/2024, indicated Resident 11 had severe cognitive impairment and had unclear speech. She could only understand others and make herself understood some of the time.	F 0744	The facility is alleged to be out of compliance by failing to prevent a resident with dementia from wandering into other residents' rooms for 1 of 3 residents reviewed to dementia care. (Resident 53) A Resident was provided a 1:1 activity to prevent further wondering into other resident's rooms. B Residents with dementia were reviewed for wandering behaviors and care plans updated C Nursing staff and Activities were educated by DON for Dementia Care. D An audit will be completed by Activities/designee for 1 on 1 care for residents with dementia three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	06/07/2024

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	A Care Plan, dated 8/17/2023, indicated Resident 53 had cognitive loss related to short and long term memory loss, severely impaired cognitive skills and abilities. Interventions included, but were not limited to: ask yes or no questions; encourage and invite to activities to keep occupied; anticipate and meet needs. A Care Plan dated, 8/17/2023, indicated Resident 53 had potential for elopement and possible injury related to Alzheimer's Disease and dementia, poor safety awareness, wandering and exit seeking behaviors. Interventions included, but were not limited to: wandergard placement and function check; provide hazard free environment; invite/escort to low stress activities to keep time occupied; if wandering in and out of other resident's rooms, attempt to learn what she is looking for. Use Velcro STOP signs on other resident's rooms; redirect to common area chair to take rest breaks from repetitive pacing/wandering; escort to watch television. During an observation on 5/1/2024 at 2:10 P.M., Resident 53 was walking around East Unit and went into room 1134. The resident was playing with a stuffed toy in room 1134 and no other residents were in the room. On 5/2/2024 at 2:27 P.M., Resident 53 entered room 1135 while Resident 11 was being interviewed by a State Surveyor. Resident 53 walked around the room, picked up the call light and put it down, and exited the room without saying anything. Resident 53 then walked across the hall and into room 1134. During an interview on 5/2/2024 at 2:28 P.M., RN 7 did not know the location of Resident 53. RN 7 went to room 1134 and walked out with Resident			

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	53. During an observation on 5/2/2024 at 2:38 P.M., Resident 53 seen walking on East Unit and entering room 1134. The resident was seen entering the room by staff and was escorted out of the room. During an interview on 5/3/2024 at 9:54 A.M., CNA 9 indicated Resident 53 did wander in and out of other residents' rooms. The resident would enter the rooms when the door was closed. The only thing that helped is if staff take the resident by the hand and lead her somewhere else. The Velcro STOP signs did not help and staff did not use them. During an interview on 5/3/2024 at 10:12 A.M., RN 10 indicated she has worked on the unit regularly for the last couple of months and staff does not use the Velcro STOP signs on the resident's Care Plan because the signs were ineffective at keeping Resident 53 out of other resident's rooms. She had been alerted by other residents that Resident 53 was in their room or had taken their belongings. RN 10 tries to keep an eye on her and redirect her but the resident enjoys walking for most of the day. During an interview on 5/3/2024 at 1:33 P.M., the Director of Nursing (DON) indicated Resident 53 did wander in and out of other residents' room and had taken belongings from other residents, but all items were either returned or replaced. The care plan for the resident's wandering had ineffective interventions and the staff would work to find interventions that prevented the resident from wandering in other residents' room. On 5/3/2024 at 1:47 P.M., the DON provided a			

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	policy, dated, 3/1/2023 and titled, "Elopement and Unsafe Wandering." The DON indicated it was the policy currently used by the facility. The policy indicated, "The facility ensures that residents who exhibit wandering behavior and or are are risk for elopement receive adequate supervision to prevent... 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk... implementing interventions to reduce hazards and risks...." On 5/3/2024 at 1:47 P.M., the DON provided a policy, dated, 3/1/2023 and titled, "Dementia Care." The DON indicated it was the policy currently used by the facility. The policy indicated, "... 4. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. 5. Individualized, non-pharmacological approaches to care will be utilized, to include meaningful activities aimed at enhancing the resident's well-being...." 3.1-37			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.			

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	§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, record review, and interview, the facility failed to ensure shift narcotic counts sheets were completed and documented every shift for 1 of 2 narcotic books observed. (West Hall) Finding includes: During a medication storage observation on 5/3/2024 at 1:26 P.M. with RN 11, the narcotic sheets, dated 1/12/2024 to 4/8/2024, indicated not all shifts had all signatures to indicate the narcotics were counted every shift. There were 7 missing signatures for the day shift and 26 missing signatures for the evening and the	F 0755	The facility is alleged to be out of compliance by failing to ensure shift narcotic count sheets were completed and documented every shift for 1 of 2 narcotic books observed. (West Hall) A Nursing staff was educated immediately on counting narcotics each shift for missing count signatures. B Audits of all narcotic books were conducted to identify any other missed counts x 90 days. Nursing staff who failed to count were educated. C Nursing staff were educated	06/07/2024

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	night shifts. During an interview on 5/3/2024 at 1:27 P.M., RN 11 indicated the narcotics should be counted every shift and documented on the sheet. On 5/3/2024 at 1:47 P.M., the Director of Nursing provided the policy titled," Controlled Substance Administration and Accountability Policy", dated 4/8/2023, and indicated the policy was the one currently being used by the facility. The policy indicated"... 2. Storage and Security: ...b. Areas without automated dispensing systems utilize substantially-constructed storage unit with two locks and paper system for 24 hour recording of controlled substance use.... 3.1-25(e)(2) 3.1-25(e)(3)		by the DON on Controlled Substance Administration and Accountability Policy. D An audit will be completed by the DON/designee of narcotic count sheets. Audits will be completed three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse			

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	155672	A. BUILDING 00 B. WING	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN 46552

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	consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure a resident who received an opioid and an anti-anxiety medication had an appropriate indication and was monitored for adverse side effects, for 1 of 5 residents whose medications were reviewed. (Resident 7) Finding includes: During an observation on 4/29/2024 at 12:27 P.M., Resident 7 was observed sitting in her wheelchair in the dining area yelling "hey hey", and scratching her back on the wheelchair back. The resident, while being fed, was observed trying to scratch her back against the back of the wheelchair. During an observation on 4/30/2024 at 9:27 A.M., Resident 7 was observed sleeping in her wheelchair in the lounge area. During an observation on 5/2/2024 at 2:20 P.M., Resident 7 was observed sleeping in her wheelchair in the lounge area. During an observation on 5/2/2024 at 2:26 P.M., Resident 7's back had no red or open areas. A record review was completed on 5/2/2024 at 2:30 P.M. Resident 7's diagnoses included, but were not limited to, dementia, depression, anxiety and osteoarthritis. Current Physician Orders included: Lorazepam	F 0757	The facility is alleged to be out of compliance by failing to ensure a resident who received an opioid and an anti-anxiety medication had an appropriate indication and was monitored for adverse side effects, for 1 of 5 residents whose medications were reviewed. (Resident 7) A Resident was assessed immediately for possible adverse side effects an opioid medication and anti-anxiety and AIMS completed. Resident was assessed for itching. Skin is intact with no redness, welts, or s/s of itching. Resident has no signs of an allergic reaction. B Audit was conducted to identify residents receiving an opioid or anti-anxiety medication for appropriate indication and for adverse side effects. None identified. C Nursing staff were educated by the DON on observing effectiveness and for adverse side effects of pain management and anti-anxiety medication. D An audit will be completed by the DON/designee of residents receiving opioids and anti-anxiety medications. Audits will be completed three times a week for	06/07/2024

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	(anti anxiety) 0.25 ml (milliliter) give every 2 hours PRN (as needed) for anxiety disorder and Morphine (narcotic) 0.25 ml (0.5 milligram) every 2 hours as needed for pain and dyspenea (labored breathing). A Quartley MDS (Minimum Data Set) assessment, dated 2/5/2024, indicated the resident received an antidepressant medication only. A Care Plan, dated 10/14/2021, indicated the resident was at risk for alteration in comfort secondary to diagnoses of osteoporosis, chronic ischemic heart disease and depression. Interventions included, but were not limited to, administer analgesic medication as ordered, observe for effectiveness/side effects, observe for non-verbal signs and symptoms of pain such as: facial grimacing, crying, moaning, restlessness, agitation, guarding or withdrawing form touch to affected area. Provide alternative comfort measures such as: therapeutic touch/massage, repositioning, toileting, calm quiet environment. Complete a pain assessment quarterly and PRN (as needed). The Medication Administration Record (MAR), dated April 2024, indicated Resident 7 received the Lorazepam and the Morphine medications 10 times on the same dates and the same times. The clinical record lacked the documentation for why the medications had been given. Nurses's Notes, dated April 1st through the 30th, lacked the documentation of any nonpharmacological interventions tried prior to administering the narcotic pain medication or the anti-anxiety medication.		4 weeks, twice a week for 4 weeks, weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	

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	During an interview on 5/02/2024 at 3:04 P.M., CNA 5 indicated when the resident yelled out, she would walk her, lie her down, or rub her back. During an interview on 5/3/24 at 2:49 P.M., the Assistant Director if Nursing (ADON) indicted the medications Ativan & Morphine should not be given together, staff should have tried a nonpharmacological interventions first, then given one of the medications. There should have been a pain scale documented when giving the morphine. The resident should have been assessed for pain and documented on the chart. On 5/3/2024 at 2:56 P.M., the ADON provided the policy titled, "Pain Management", dated 10/24/2022, and indicated the policy was the one currently used by the facility. The policy indicated"...The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences...Pain Management and Treatment:... f. Reassess and adjust the medication dose to optimize the residents's pain relief while monitoring the effectiveness of the medication and work to minimize or manage side effects...8. Monitoring,, Reassessment and Care Plan Revision. a. Facility staff will reassess resident's pain management at establish intervals for effectiveness and/or adverse consequences such as:...viii. Itching.... On 5/3/2024 at 11:10 A.M., the ADON provided the policy titled, "Unnecessary Drugs- Indications for Usage", dated 8/12/2022, and indicated the policy was the one currently used by the facility. The policy indicated:...3. Documentation will be provided in the resident's medical record to show			

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	adequate indications for the medication's use...." 3.1-37			
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 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, record review, and interview, the facility failed to ensure expired medications were removed from the medication cart and failed to monitor a medication refrigerator's temperature to prevent a large build up of ice in 1 of 1 medication cart and 1 of 1 medication rooms observed. (West Medication	F 0761	The facility is alleged to be out of compliance by failing to ensure expired medications were removed from the medication cart and failed to monitor a medication refrigerator’s temperature to prevent a large build up of ice in 1	06/07/2024

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	Cart & East Medication Room) Findings include: 1. On 5/3/2024 at 1:26 P.M. with RN 11 a medication storage observation was completed on the West medication cart. The following was observed: an opened bottle of lactulose liquid that had expired on 1/9/2024, and two opened bottles of Guafenesin syrup with expiration dates of 2/22/2024 and 3/2024. During an interview on 5/3/2024 at 1:35 P.M., RN 11 indicated the medications should have been removed from the cart. 2. During a medication storage observation on 5/3/2024 at 1:39 P.M. with RN 10, the following was observed on the East unit: the medication refrigerator had a large build up of ice in the freezer section of the fridge. The February temperature log sheet indicated the temperature was not documented 1 time for the AM temperature and 11 times for the PM temperature. The March temperature log sheet indicated the temperature was not documented 2 times for the AM temperature and 17 times for the PM temperature. During an interview on 5/3/2024 at 1:42 P.M., RN 10 indicated there should be no ice in the freezer section, and temperatures should be documented twice a day. A policy was requested on 5/3/2024 but one was not provided prior to the survey exit.		of 1 medication cart and 1 of 1 medication rooms observed. A Expired medication was removed from cart and refrigerator was defrosted. B The remaining medication carts were audited and no other expired medications were identified, remaining medication refrigerators were checked and no other ice buildup was identified. C Nursing staff were educated by the DON on Labeling of Medications and monitoring medication refrigeration temperatures. D An audit will be completed by the DON/designee of medication rooms and medication carts. Audits will be completed three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and results reported in QAPI.	

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	3.1-25(m) 3.1-25(o)			
F 9999 Bldg. 00	3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not limited to, the following: (1) Resident Rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents.. (7) Documentation of orientation to the facility and to the specific job skills. This state rule is not met as evidenced by: Based on interview and record review, the facility failed to provide timely general orientation and education on resident rights and abuse prior to starting dates for 3 of 9 employee files reviewed. (CNA 12, Dietary Aide 13, and CNA 14) This state rule is not met as evidenced by: Findings include: During the review of the Employee Personnel files, conducted on 5/3/2024 and 5/6/2024 at 3:27 P.M., the following was observed: a. CNA 12, hired on 7/17/2023, did not have the facility general orientation, resident rights or abuse education documented as completed until 8/24/2023.	F 9999	The facility is alleged to be out of compliance by failing to provide timely general orientation and education on resident's rights and abuse prior to starting dates for 3 of 9 employee files reviewed. (CNA 12, Dietary Aide 13, and CNA 14) A Employees completed general orientation, resident's rights, and abuse training. B Employee files were audited for general orientation, resident rights and abuse training. C Human Resources were educated by the Administrator regarding employee files. HR checklist was created to ensure require mandatory trainings are completed prior to beginning resident care. D An audit will be completed by Human Resources three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and reported in QAPI.	06/07/2024

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	b. Dietary Aide 13, hired on 7/11/2023, did not have the facility general orientation, resident rights or abuse education documented as completed until 8/24/2023. c. CNA 14, hired on 1/30/2024, did not have abuse education documented as completed until 2/1/2024, resident rights on 2/2/2024 and the facility general orientation documented as completed until 4/19/2024. During an interview on 5/6/2024 at 3:05 P.M., the Human Resources Manager indicated the general orientations, and the education for resident rights and abuse should have been done on hire. There was no further information to provide. On 5/6/2024 at 3:41 P.M., the Human Resource Manager provided the policy titled, "Training Requirements", dated 10/24/2022, and indicated the policy was the one currently used by the facility. The policy indicated..." 5. Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. 6. Training content includes, at a minimum: ...b. Resident rights and facility responsibilities for caring of residents...h. Abuse, neglect, and exploitation prevention...."			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: April 29, 30 & May 1, 2, 3, & 6.	R 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists	

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	Facility number: 000427 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 5/9/24.		or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	
R 0026 Bldg. 00	410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on record review and interview, the facility failed to maintain a signed copy of Resident Rights in residents' records for 2 of 5 residents who were reviewed for Resident Rights. (Residents 6 & 7) Findings include:	R 0026	R 026 The community was alleged to be out of compliance by failing to ensure each resident has a Resident Right acknowledgement form signed in Medical Records upon admission for 2 of 5	06/07/2024

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	1. Resident 6's record review was completed on 4/6/2024 at 11:00 A.M. Resident 6 was admitted on 2/24/2023. Resident 6's record lacked the documentation she had received and signed the Resident Rights upon admission. During an interview on 5/6/2024 at 3:00 P.M., the Assistant Director of Nursing (ADON) indicated Resident 6 did not have a signed copy of the Resident Rights in her record. 2. Resident 7's record review was completed on 4/6/2024 at 1:05 P.M. Resident 7 was admitted on 2/21/2015. Resident 7's record lacked the documentation she had received and signed the Resident Rights upon admission. During an interview, on 5/6/2024 at 3:01 P.M., the Assistant Director of Nursing indicated Resident 7 did not have a signed copy of the Resident Rights in her record. On 4/6/2024 at 3:55 P.M., the Assistant Director of Nursing provided a policy, dated, 5/8/2023, and titled, "Resident Rights." The Assistant Director of Nursing indicated it was the policy the facility currently used. The policy indicated, "The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility... 2. Information about resident rights and responsibilities will be given to the resident both orally and in writing...."		residents. (Residents 6 &7) A The Medical Record for Resident 6 was updated with a signed Resident Rights acknowledgement form. Resident 7 Resident Rights were located. B Residents Records were reviewed to ensure each resident received a resident rights acknowledgement form. C Nursing staff was educated on completion of Resident Rights on admission. D An audit of admission medical records will be completed by the DON/designee twice a week for 4 weeks, weekly for 4 weeks and monthly thereafter until found to be in compliance. The DON/designee will report findings to QAPI committee monthly for review, recommendations, and tracking.	

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R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to provide timely general orientation and education on resident rights and abuse for 3 of 9 employee files reviewed. (CNA 12, Dietary Aide	R 0119	The community was alleged to be out of compliance by failing to provide timely general orientation and education on resident's rights	06/07/2024

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	13, and CNA 14) Findings include: During the review of the Employee Personnel files, conducted on 5/3/2024 and 5/6/2024 at 3:27 P.M., the following was noted: a. CNA 12 hired on 7/17/2023, did not have the facility general orientation, resident rights, or abuse education documented as completed until 8/24/2023. b. Dietary Aide 13, hired on 7/11/2023, did not have the facility general orientation, resident rights or abuse education documented as completed until 8/24/2023. c. CNA 14, hired on 1/30/2024, did not have abuse education documented as completed until 2/1/2024, resident rights on 2/2/2024 and the facility general orientation documented as completed until 4/19/2024. During an interview on 5/6/2024 at 3:05 P.M., the Human Resource Manager indicated the general orientations, the education for resident rights and abuse should have been done on hire. There was no further information to provide. On 5/6/ 2024 at 3:41 P.M., the Human Resource Manager provided the policy titled, "Training Requirements", dated 10/24/2022, and indicated the policy was the one currently used by the facility. The policy indicated..." 5. Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. 6. Training content includes, at a minimum: ...b. Resident rights and		and abuse prior to starting dates for 3 of 9 employee files reviewed. (CNA 12, Dietary Aide 13, and CNA 14) A Employees completed general orientation, resident's rights, and abuse training. B Employee files were audited for general orientation, resident rights and abuse training. C Human Resources were educated by the Administrator/designee regarding employee training. System review and change to request necessary trainings being completed before staff proved resident care on the units. An audit will be completed by Human Resources three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and reported in QAPI	

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	facility responsibilities for caring of residents...h. Abuse, neglect, and exploitation prevention...." 410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.			
R 0246 Bldg. 00	Based on record review and interview, the facility failed to have a QMA (Qualified Medication Aide) get authorization from a nurse before giving a PRN (as needed) medication for 2 of 5 residents reviewed for nurse authorization before PRN medications were given. (Residents 7 & 8) Findings include: 1. Resident 7's record review was completed on 5/6/2024 at 1:05 P.M. Resident 7's diagnoses included, but were not limited to: dementia, hypertension, anxiety disorder and chronic respiratory failure. A current Physician's Order, dated 2/21/2021, indicated loperamide (anti-diarrhea) every six hours, PRN. Resident 7's March 2024 MAR (Medication Administration Record) indicated QMA 17 had given Resident 7 loperamide on 3/5/2024 at 6:36 A.M. Resident 7's record lacked the documentation	R 0246	The community was alleged to be out of compliance by failing to have a QMA (Qualified Medication Aide) get authorization from a nurse before giving a PRN (as needed) medication for 2 of 5 residents reviewed for nurse authorization before PRN medications were given. (Residents 7&8) A QMA Scope of Practice was reviewed immediately with QMA. B Audit initiated to identify proper authorization of PRN medications, administered by QMAs. C Nursing staff were educated by DON/designee on Qualified Medication Aide Scope of Practice. D An audit will be completed by DON three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks and monthly thereafter until found to be in	06/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 00 B. WING	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN 46552

(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
	indicating QMA 17 had received authorization from a nurse before administering the loperamide. During an interview, on 5/6/2024 at 3:02 P.M., the Assistant Director of Nursing indicated Resident 7 did not have the documentation in her record to show QMA 17 had authorization from a nurse prior to giving the PRN medication.2. A record review for Resident 8 was conducted on 5/6/2024 at 1:32 P.M. Diagnoses included, but were not limited to unspecified fracture of left pubis. Physician Orders included, but were not limited to: 8/20/2022 Tramadol 50 milligrams (mg) 1 tablet by mouth 3 times a day as needed for pain 3/17/2023 Lomotil 5 mg/0.05 mg by mouth 4 times a day as needed for diarrhea. The Medication Administration Records (MAR), dated December 2023 through March 2024, indicated as needed (PRN) medications were administered by a Qualified Medication Aide (QMA), without authorization by a licensed nurse, on the following dates: 3/17/2024 at 9:55 P.M. Tramadol 50 mg by QMA 15. 2/13/2024 at 4:30 P.M. Tramadol 50 mg by QMA 15. 2/13/2024 at 4:30 P.M. Lomotil 0.5 mg by QMA 15. 1/24/2024 at 8:10 P.M. Tramadol 50 mg by QMA 16. 12/18/2023 at 11:53 P.M. Tramadol 50 mg by QMA 17. The record lacked documentation that the QMA obtained authorization from a licensed nurse before administering PRN medications. During an interview on 5/6/2024 at 12:04 P.M., the ADON indicated QMAs should obtain		substantial compliance. Results will be reviewed by QAA and reported in QAPI	

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	authorization by a licensed nurse and if there is not a note in the interdisciplinary notes then the QMA did not get authorization. On 5/6/2024 at 3:24 P.M., the ADON provided an undated document titled, "Qualified Medication Aide Scope of Practice" and indicated this is the current policy. The document included, but was not limited to, "...(11) Administer previously ordered PRN medication only if authorization is obtained from the facility's licensed nurse on duty or on call...."			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, record review, and interview, the facility failed to ensure medications in a resident's apartment were secured from other residents, for 1 of 3 resident apartments observed. (Resident 8) During an observation in Resident 8's apartment on 5/6/2024 at 11:11 A.M., medications were found on a table by the window. Resident 8 indicated staff administered her medications, but she kept Tylenol and ibuprofen in her apartment. Medications found on the table included Tylenol, Ibuprofen and Vitamin C. A record review for Resident 8 was conducted on 5/6/2024 at 1:32 P.M. Diagnoses included, but were not limited to, unspecified fracture of left pubis. Physician Orders included, but were not limited to: 8/20/2022 acetaminophen 325 milligrams (mg) 2	R 0295	The community was alleged to be out of compliance by failing to ensure medications in a resident's apartment were secure from other residents, for 1 of 3 resident apartments observed. (Resident 8) A Resident was asked to lock apartment when unattended. B A house wide audit was completed to ensure MD orders, self administration of medications, and proper storage for residents who self medicate. C Nursing staff were educated by DON/designee on Resident Self Administration of Medications. D An audit will be completed by DON three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks and monthly	06/07/2024

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	tabs by mouth 3 times a day for pain. The record lacked physician orders for any as needed acetaminophen, ibuprofen, and vitamin C. The record also lacked a physician order for self administration of medications. During an interview on 5/6/2024 at 12:04 P.M., the ADON indicated that Resident 8 should not have medications in her room. On 5/6/2024 at 3:24 P.M. the ADON provided a current policy titled, "Resident Self Administration of Medications" and dated 12/14/2023. The policy included, but was not limited to, "...The following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective...."		thereafter until found to be in substantial compliance. Results will be reviewed by QAA and reported in QAPI.	
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on record review and interview, the facility	R 0298	The facility found the records in	06/07/2024

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	failed to have a Pharmacist review a resident's medications at least every 60 days, for 1 of 5 residents who were reviewed for Pharmacist Reviews. (Resident 7) Finding includes: Resident 7's record review was completed on 4/6/2024 at 1:05 P.M. Resident 7's record indicated a Pharmacist had reviewed her medications on 5/9/2023, 9/1/2023, 10/26/2023, 12/20/2023, 2/13/2024 and 4/10/2024. There was no review completed within 60 days of the 5/9/23 review. During an interview on 5/6/2024 at 3:04 P.M., the Assistant Director of Nursing indicated Resident 7 did not have a Pharmacist Review for her medications in June, July, or August, 2023. On 5/6/2024 at 3:21 P.M., the Assistant Director of Nursing provided a policy, dated, 4/13/2019, and titled, "Medication Reconciliation", and indicated it was the policy currently used by the facility. The policy indicated, "... 7. Monthly Processes: a. Provide pharmacy consultant access to all medication areas and records for completion of pharmacy services activities...."		question. The community was alleged to be out of compliance by failing to have a pharmacist review a resident's medications at least every 60 days, for 1 of 5 residents who were reviewed for Pharmacist Reviews. (Resident 7) 1.Pharmacy reviews were located for Resident #7 B B. A house wide audit was completed to identify timely pharmacy reviews. 1.Nursing staff were educated by DON/designee on Medication Reconciliation. Medical Records was educated to scan pharmacy recommendations into the E.H.R. D D. An audit will be completed by DON three times a week for 4 weeks, twice a week for 4 weeks, weekly for 4 weeks and monthly thereafter until found to be in substantial compliance. Results will be reviewed by QAA and reported in QAPI.	