STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155793	A. BUILDING 00 B. WING	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMILTON TRACE OF FISHERS	11851 CUMBERLAND RD FISHERS, IN 46037

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00444953. This visit included a State Residential Licensure Survey. Complaint IN00444953 - Federal/State deficiencies related to the allegations are cited at F550, F583, and F661. Survey dates: May 5, 6, 7, 8, 9, and 12, 2025 Facility number: 012644 Provider number: 155793 AIM number: 201046710 Census Bed Type: SNF/NF: 54 SNF: 42 Residential: 70 Total: 166 Census Payor Type: Medicare: 19 Medicaid: 30 Other: 47 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 15, 2025.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this SOD Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.	
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on interview and record review, the facility failed to promote a dignified environment with not	F 0550	1 What corrective action(s) will be accomplished for those	06/06/2025

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

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	providing care and services timely and ensure a resident was dressed in street clothes while dining in the facility dining room for 14 of 18 residents reviewed for resident council, 3 of 7 residents reviewed for Activities of Daily Living, 1 of 4 residents reviewed for staffing and 2 of 2 residents randomly observed. (Resident D, Resident E, Resident F, Resident G, Resident H, Resident J, Resident K, Resident L, Resident M, Resident N, Resident O, Resident P, Resident Q, Resident R, Resident S, Resident T, Resident X, Resident V, Resident W, Resident Z, Resident DD, Resident EE and Resident C) Findings include: 1. The clinical record for Resident V was reviewed on 5/12/25 at 11:12 a.m. An Admission Minimum Data Set (MDS) assessment, dated 3/21/25, indicated the resident was cognitively intact. On 5/7/25 at 9:53 a.m., Resident V's call light was observed to be on for approximately five minutes. Certified Nurse Aide (CNA) 8 walked past the room and did not go in to answer the call light. Registered Nurse (RN) 5 was at the nurse's station where the call light board was located. On 5/7/25 at 10:13 a.m., Resident V was observed sitting on the edge of her bed with her underwear pulled down to her knees. Her call light was still on. On 5/7/25 at 10:15 a.m., CNA 8 entered Resident V's room and answered her call light. RN 5 was at the nurse's station. 2. The clinical record for Resident L was reviewed on 5/5/25 at 11:40 a.m. The diagnoses included, but were not limited to, chronic kidney disease.		residents found to have been affected by the deficient practice? Resident C discharged facility per plan of care Resident(s) E, F, G, H, J, K, L, M, N, O, P, Q, R, S, T, X, V, W, Z, DD, EE did not experience any adverse effects related to the alleged deficient practices. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents residing in the facility have the potential to be affected by the alleged deficient practice and have been audited to ensure care and services are provided timely and residents are dressed appropriately in the dining room. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing associates have been educated to assist residents with dressing prior to escorting to the dining room and regarding the call light policy. Education will occur upon hire and annually. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur,	

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	A Quarterly MDS assessment, dated 2/10/25, indicated the resident was cognitively intact. An interview was conducted with Resident L on 5/5/25 at 11:31 a.m. She indicated it took up to 45 minutes at times for staff to provide services after pressing her call light to go to the bathroom. 3. The clinical record for Resident M was reviewed on 5/5/25 at 12:00 p.m. The diagnoses included, but were not limited to, hypertension. A Quarterly MDS assessment, dated 2/12/25, indicated the resident was cognitively impaired. An interview was conducted with Resident M on 5/5/25 at 1:22 p.m. She indicated there were delays with call light response times, especially on the weekends. It has taken an hour and a half for the staff to address the needs after pressing her call light. 4. The clinical record for Resident DD was reviewed on 5/6/25 at 11:00 a.m. The diagnoses included, but were not limited to, cellulitis. During an interview with Resident DD on 5/6/25 at 11:03 a.m., she indicated she had to wait over an hour to get her needs met at times after pressing her call light. If it was during meal service; she had been told she would have to wait until meal service was completed before she could receive pain medication. 5. The February 2025, March 2025, and April 2025 resident council minutes were provided by the Executive Director (ED) on 5/6/25 at 1:24 p.m. The attendees in the meetings included, but were not limited to, Resident R, Resident Z, Resident X, Resident F, Resident N, Resident H, Resident T,		i.e., what quality assurance program will be put into place? DON or designee will audit 5 residents to ensure that they are dressed appropriately in the dining room and that call lights are being answered in a timely manner. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	

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	Resident Q, Resident D, Resident J, Resident G, and Resident O. The resident council had concerns with nursing call light response times for the February 2025, March 2025, and April 2025 resident council meetings. The facility's response and resolution to the resident council concerns were education to the staff. The in-service education provided to the staff included the following: Call light response times, dated 3/4/25, indicated "call lights shall be answered within a timely manner. Goal is 10 minutes or less. Nurses are to assist in answering call lights. All staff, including non-clinical staff, shall not pass a room with a call light on. Please answer the call light, acknowledge the need and report to the appropriate staff member..." Call light response times, dated 3/25/25, indicated "Ensure residents' call lights are answered as soon as possible. If unable to answer due to caring for another resident, please let the resident know you acknowledged their need and will be with them as soon as possible. Nurses, please assist with answering call lights to address resident needs as soon as possible. All staff shall not pass a resident room with a call light on. Anyone can answer a call light. Please enter the room, introduce yourself and ask them what you can do to help. If you are not able to address their needs, please seek someone from the nursing staff..." A resident council meeting was conducted on 5/7/25 at 10:07 a.m. The attendees were the following: Resident W, Resident W's Representative, Resident X, Resident N, Resident P, Resident K, Resident H, Resident E, Resident J, Resident EE, and Resident S. During that meeting,			

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	5 of 11 residents voiced concerns regarding the staff not responding to call lights timely. During an interview with the Director of Nursing on 5/9/25 at 10:55 a.m., he indicated there can be delays on answering call lights during high care activity times. 6. The clinical record for Resident C was reviewed on 5/5/25 at 3:18 p.m. The diagnoses included, but were not limited to, cellulitis (infection) of left lower limb and depression. She was admitted to the facility on 4/29/25. An Admission MDS assessment, completed 5/7/25, indicated she was cognitively intact. On 5/5/25 at 12:24 p.m., Resident C was observed at a table in the unit dining room. She was sitting in a wheelchair and dressed in a hospital gown. Part of her back was visible above the wheelchair back. On 5/5/25 at 3:18 p.m., Resident C was observed in her room sitting in her wheelchair. She was still dressed in a hospital gown. A suitcase with visible clothing items was on the floor of her room. Resident C indicated she had wanted to get dressed prior to going to therapy that morning. She normally got up and dressed around 5:00 a.m. She had clothes available to wear in her suitcase. A resident rights policy was provided by the Executive Director on 5/9/25 at 8:45 a.m. It indicated, "...[Name of Facility Corporation] and its member communities are committed to protecting and promoting the rights of the residents who reside in our communities... 1. a dignified existence... 2. be treated with respect, kindness, and dignity... 37. Receive care in a manner and in an environment that promotes			

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	maintenance or enhancement of his or her quality of life, recognizing each resident's individuality..." This citation relates to Complaint IN00444953. 3.1-3(t)			
F 0577 SS=C Bldg. 00	483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info Based on observation, interview, and record review, the facility failed to have the most recent survey results available in the survey binder with the potential to affect 97 of 97 residents currently residing at the facility. Findings include: On 5/7/25 at 10:07 a.m., a resident council meeting was conducted at the facility. During the resident council meeting, a family member indicated they had attempted to read the most recent survey results in the Facility Survey Binder, located by the front entrance. They were unable to view the most recent facility survey. The binder contained survey information from 2022. On 5/7/25 at 10:50 a.m., the Facility Survey Binder was observed with the Executive Director. The most recent survey present in the binder was from December 2022. The Executive Director indicated the Annual Recertification Survey, conducted March 2024, should have been included in the State Survey Binder. He was unsure as to why it was not there. 3.1-3(b)(1)	F 0577	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The survey binder was updated with the most recent survey results during the survey. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents residing in the facility have the potential to be affected by the alleged deficient practice. The survey binder was updated with the most recent survey results during the survey. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Administrator was educated to ensure the survey binder is updated with the most recent survey results. This education will occur annually.	06/06/2025

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			4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The administrator or designee will audit the survey binder to ensure the most recent survey results are available. Audits will occur weekly x 12 weeks, then monthly for 7 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records Based on interview and record review, the facility failed to ensure a resident's medical record was kept private and confidential by giving a resident the wrong medical record in error at discharge for 1 of 3 residents reviewed for discharge. (Resident B and Resident E) Findings include: A. The clinical record for Resident B was reviewed on 5/7/25 at 9:35 a.m. The diagnoses included, but were not limited to, stroke. The resident was discharged from the facility on 10/10/24. B. The clinical record for Resident E was reviewed	F 0583	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B and E no longer reside in the facility 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents who discharge from the facility have the potential to be affected by the alleged deficient	06/06/2025

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	on 5/12/25 at 12:27 p.m. The diagnoses included, but were not limited to, pain. The resident was discharged from the facility on 10/10/24. During a Confidential Interview, Resident B was given Resident E's medical record at the time of discharge. It was not recognized until 24 hours after discharge from the facility. Resident B had gone to the emergency room with the medical chart that had been given to her by the facility at discharge. At that time, the hospital staff recognized Resident B had been given the wrong resident's medical chart and notified the facility. An interview was conducted with the Executive Director (ED) and the Director of Nursing (DON) on 5/7/25 at 2:22 p.m. The ED indicated Resident B had received Resident E's medical record at the time of discharge by error. Both residents were discharged on the same day, 10/10/24. The medical records were placed in folders sitting on top of the nurse's station. The nurse gave Resident E's medical chart to Resident B by error. A resident rights policy was provided by the ED on 5/9/25 at 8:45 a.m. It indicated "...[Name of Facility Corporation] and its member communities are committed to protecting and promoting the rights of the residents who reside in our communities... 17. Access personal and medical records pertaining to him or herself... 20. Privacy and confidentiality..." This citation is related to Complaint IN00444953. 3.1-3(o)		practice. Discharges for the last 30 days have been audited to ensure the correct medical record information is provided at discharge. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses were educated to ensure the correct medical record information is provided at discharge. The systemic change includes two nurses to verify the correct medical record information is provided at discharge. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON or designee will audit 5 discharges to ensure the correct medical record information is provided at discharge. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality	

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F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances Based on interview and record review, the facility failed to timely initiate and address a grievance for 1 of 2 residents reviewed for choices (Resident DD). Findings include: The clinical record for Resident DD was reviewed on 5/6/25 at 10:41 a.m. The diagnoses included, but were not limited to, cellulitis (infection) of the right lower limb. She was admitted on 4/22/25. A care plan, last reviewed 5/1/25, indicated Resident DD had acute pain related to cellulitis to the right lower extremity and a wound to the right heel. She also had complaints about back pain. She was able to report pain and efficacy of interventions. The goal was for her to have pain levels maintained at a consistent level of comfort while retaining as much function as possible. The interventions were to observe for side effects of treatment interventions, observe for efficacy of interventions, apply non-pharmacological intervention, treatment, and/or removal of the root cause of pain until the issue was resolved, and to monitor vital signs During an interview on 5/6/25 at 10:41 a.m., Resident DD indicated the mattress on her bed was uncomfortable and hurt her back. She had told "everyone" that the mattress hurt her back. She had asked for a different mattress, but no one had offered to change the mattress for her. After about four hours of lying in bed, she had the staff	F 0585	Assurance Committee. 1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident DD discharged from the facility per the plan of care. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents who have grievances regarding mattress comfort have the potential to be affected by the alleged deficient practice and have been audited to ensure grievances regarding mattress comfort have been addressed. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Caring Hearts Representatives have been educated regarding the grievance process. Education will occur upon hire and annually. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	06/06/2025

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	get her up in her wheelchair because the bed hurt her back so badly. During an interview on 5/7/25 at 9:35 a.m., Resident DD indicated she had been up in her wheelchair most of the night because her back hurt when she was in bed. She had told the staff each day that the mattress made her back hurt. She had been told three different times that a recliner could be provided for her to sleep in, but no one ever brought one. She had slept in a recliner at home in the past. During an interview on 5/8/25 at 3:33 p.m., the Executive Director (ED) indicated there were no grievances for Resident DD. The facility used the Caring Heart's Program to address grievances and concerns. An employee was assigned to each room to check on residents' daily and see if the resident had any concerns. The Admissions Assistant was the employee assigned to Resident DD. During an interview on 5/8/25 at 3:33 p.m., the Director of Nursing (DON) indicated he had not been made aware that Resident DD had requested a recliner or that she had a problem with her mattress. During an interview on 5/8/25 at 3:40 p.m., Resident DD indicated many staff members had stopped during her stay to see how things were going. She had told the Certified Nurse Aides who provided care for her that the bed and mattress hurt her back. She had also told the male nurse who had cared for her about the mattress. Resident DD could not remember a specific staff member that had stopped daily to see if she had any concerns. She was unaware of the "Caring Heart" program. Earlier in the day, the facility had		DON/designee will interview 5 residents to ensure grievances regarding mattress comfort are addressed timely. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	

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	brought in a recliner for her to use and she was hoping to get some rest soon. During an interview on 5/8/25 at 3:48 p.m., Registered Nurse (RN) 20 and RN 21 indicated they did not believe there were forms available on the unit to use for concerns or grievances. If a resident or resident representative had a concern, RN 20 and RN 21 would attempt to contact the department in charge of the concern or let their Unit Manager know. On 5/7/25 at 1:44 p.m., the ED provided the current Caring Hearts Policy and Procedure which indicated "...has implemented the Caring Hearts program to improve our resident's experience and to provide good customer service...When a resident, guest or family member is not satisfied with the resident's room, the service[s] being provided, work done by a department, the environment or any other complaint a 'Grievance Form' ...shall be completed. The grievance form should be completed at the time an issue is raised and given to the Administrator/ Executive Director [or delegated associate] immediately...If during an interview or when rounding a grievance is raised by a resident then the 'Grievance Form'...shall be completed immediately..." On 5/12/25 at 2:10 p.m., the Clinical Nurse Consultant provided the current Filing Grievances/Complaints policy which indicated "...Grievances and/ or complaints may be submitted orally or in writing. Written complaints or grievances must be signed by the resident or the person filing the grievance or complaint on behalf of the resident... Upon receipt of the grievance and/ or complaint... will investigate the allegation and submit a written report of such findings to the Administrator within five [5]			

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	working days of receiving the grievance and/ or complaint..." 3.1-7(a)(2)			
F 0645 SS=D Bldg. 00	483.20(k)(1)-(3) PASARR Screening for MD & ID Based on interview and record review, the facility failed to ensure a timely Level I and Level II screening was obtained for 1 of 1 resident reviewed for Pre-Admission Screening and Resident Review (PASRR). (Resident 16) Findings include: The clinical record for Resident 16 was reviewed on 5/6/25 at 2:13 p.m. The resident was admitted on 9/30/24. Diagnoses included, but were not limited to, dementia, bipolar disorder (a mood disorder characterized by episodes of mania and depression), and depression. A facility Social Services Admission Screening, dated 10/2/24, indicated the resident did have diagnoses which may impact adjustment, such as dementia or bipolar disorder. The Executive Director provided a Level I PASRR screen on 5/7/25 at 1:36 p.m. It indicated the facility completed the screening on 4/9/25. The screening also indicated "Reason for screening: This nursing facility resident has never had a PASRR Level I screen." The Social Services Director (SSD) was interviewed on 5/7/25 at 4:28 p.m. She indicated there was no other screening done. She wasn't sure if the resident had admitted with one already	F 0645	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Level 1 and Level 2 have been obtained for Resident 16. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents residing in the facility have the potential to be affected by the alleged deficient practice and have been audited to ensure the Level 1 and/or Level 2 are obtained for Preadmission Screening and Resident Review (PASRR). 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Admissions associates educated regarding the process for obtaining Level 1 and/or Level 2 for Preadmission Screening and Resident Review (PASSR).	06/06/2025

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	completed. She was not sure how long after admission, a Level I was supposed to be done. She would have to ask the previous director. The Director of Nursing (DON) was interviewed on 5/12/25 at 1:50 p.m. He indicated they did not have a PASRR policy. The ED provided a printed PASRR entry report on 5/12/25 at 1:45 p.m. It indicated the following: -A Level I screen draft was started, but was withdrawn, on 10/1/24. -A Level I screen was started, but expired, on 10/18/24, 11/8/24, and 12/3/24. -A Level I screen was completed and referred for a Level II screening on 4/9/25. 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON or Administrator will audit new admissions to ensure PASSR is completed. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary Based on interview and record review, the facility failed to ensure a resident received a discharge summary at the time of discharge for 1 of 3 residents reviewed for discharge. (Resident B) Findings include: A. The clinical record for Resident B was reviewed on 5/7/25 at 9:35 a.m. The diagnoses included, but were not limited to, stroke. The resident was discharged from the facility on 10/10/24. During a Confidential Interview, Resident B was given Resident E's medical record at the time of	F 0661	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B no longer resides in the facility. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents who discharge from the facility have the potential to be	06/06/2025

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	discharge. She did not receive any of Resident B's medical or discharge information. An interview was conducted with the Executive Director (ED) and the Director of Nursing (DON) on 5/7/25 at 2:22 p.m. The ED indicated Resident B had received Resident E's medical record at the time of discharge by error. Both residents were discharged on the same day, 10/10/24. The medical records were placed in folders sitting on top of the nurse's station. The nurse gave Resident E's medical chart to Resident B by error. A discharge planning policy was provided by the ED on 5/7/25 at 1:36 p.m. It indicated "...[Name of Facility Corporation] and its member communities are committed to ensuring a resident discharge process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions...I. When the community anticipates a resident's discharge to a private residence... a discharge summary and a post discharge plan will be developed which will assist the resident to adjust to his or her living environment. II. The discharge summary will include a recapitulation of the resident's stay at this community and a final summary of the resident's status at that time of the discharge in accordance with established regulations governing release information and as permitted by the resident. The discharge summary shall include a description of the resident's: a. current diagnoses; b. medical history (including any history of mental disorders and intellectual disabilities)... c. course of illness, treatment and/or therapy since entering the facility... d. current laboratory, radiology, consultation, and diagnostic test results... e. physical and mental		affected by the alleged deficient practice. Discharges for the last 30 days have been audited to ensure discharge summaries were provided. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses educated regarding the discharge process to include a copy of the discharge summary. Education will occur upon hire and annually. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON or Administrator will interview 5 residents post-discharge to ensure receipt of a discharge summary. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	

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	functional status... f. ability to perform activities of daily living... XIII. A copy of the following will be provided to the resident and any receiving provider and a copy will be filed in the resident's medical records: a. an evaluation of the resident's discharge needs... b. The post-discharge plan... and c. The discharge summary..." This citation is related to Complaint IN00444953. 3.1-36(a)(1) 3.1-36(a)(2) 3.1-36(a)(3)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to trim a resident's nails and assist a resident with transferring timely for 2 of 7 residents reviewed for activities of daily living (ADL) care. (Resident 200 and Resident 253) Findings include: 1. The clinical record for Resident 200 was reviewed on 5/5/25 at 3:18 p.m. The diagnoses included, but were not limited to, cellulitis (infection) of the left lower limb and depression. She was admitted to the facility on 4/29/25. An Admission Minimum Data Set assessment, completed 5/7/25, indicated she was cognitively intact. During an interview on 5/5/25 at 3:18 p.m., Resident 200 indicated her nails were long and needed to be trimmed. Resident 200's nails were observed to extend well past the tips of her	F 0677	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 200's nails were trimmed, and Resident 253 was transferred to bed during the survey. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents residing in the facility have the potential to be affected by the alleged deficient practice and have been audited to ensure nails are trimmed and residents are transferred to bed upon request. 3 What measures will be put	06/06/2025

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	fingers and have worn green polish on them. On 5/7/25 at 9:54 a.m., the Executive Director provided the shower sheets for Resident 200, which indicated she had a bed bath on 5/6/25. The shower sheet did not indicate if Resident 200's fingernails had been trimmed and did not indicate refusal of such care. During an interview on 5/7/25 at 1:38 p.m., Resident 200 indicated she had received a bed bath the night before. On 5/8/25 at 11:15 a.m., Resident 200 was observed sitting in her wheelchair dressed in street clothes. Her nails were long and there was worn green polish present on them. Resident 200 indicated her nails still needed trimmed. During an interview on 5/8/25 at 11:20 a.m., Certified Nurse Aide (CNA) 2 indicated that residents nails should be trimmed on shower days and as needed. 2. The clinical record for Resident 253 was reviewed on 5/5/25 at 11:30 a.m. The diagnoses included, but were not limited, paraplegia (a condition causing partial or complete paralysis of the lower body) and repeated falls. An Annual Minimum Data Set (MDS) assessment, completed 5/4/25, indicated Resident 253 was cognitively intact. A care plan, created 5/6/25, indicated Resident 253 was at risk for falling and fall related injuries and required assistance from staff for transfers. The goal for Resident 253 was to minimize the risk of falls and fall related injuries. The interventions, created 5/6/25, included, but were not limited to, were to assist with ADLs.		into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing associates have been educated to offer and perform nail care on shower days and to assist with transfers timely. Education will occur upon hire and annually. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON or designee will audit 5 residents to ensure nails are trimmed and interview 5 residents to ensure assistance with transfers is provided timely. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	

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	During an observation on 5/5/25 at 12:30 p.m., Resident 253's call light indicator was illuminated. On 5/5/25 at 12:56 p.m., Resident 253's call light indicator was illuminated. The resident was observed grimacing while sitting in a wheelchair in her room. She indicated she had been sitting in her wheelchair for an hour and a half and needed to get back to bed because she was in pain from the wounds on her backside. Resident 253 indicated she had asked staff to transfer her back to her bed and was told staff had to pass lunch first. During an interview on 5/6/25 at 11:45 a.m., Resident 253's Representative indicated the resident had to wait for assistance during mealtimes. On 5/6/25 at 11:48 a.m., CNA 4 was observed, indicating to Resident 253 at that point in time, this would be her only opportunity to lay the resident down before lunchtime and then she would be in the dining room; otherwise, the resident would have to wait until after lunch to lay down. Resident 253 chose to lay down instead of going to the dining room for lunch. During an interview on 5/9/25 at 10:55 a.m., the Director of Nursing (DON) indicated during high care times there can be delays in care. An ADL Supporting Policy, revised March 2018, was provided by the DON on 5/12/25 at 11:27 a.m. It indicated " ...Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance			

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	with: ...b. Mobility (transfer and ambulation, including walking) ..." 3.1-38(a)(2)(B) 3.1-38(a)(3)(E)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to determine a root cause analysis of falls and to implement fall interventions, as care planned, for 3 of 5 residents reviewed for falls. (Residents' F, 33 and 68) Findings include: 1. The clinical record for Resident 33 was reviewed on 5/5/25 at 1:02 p.m. The diagnoses included but were not limited to Alzheimer's disease. A Quarterly Minimum Data Set (MDS) assessment, completed on 1/29/25, indicated severe cognitive impairment. A progress note, dated 2/24/25 at 3:26 p.m., indicated Resident 33 was seen walking into the television room. She fell after attempting to get onto the weight station. An event report, dated 2/24/25, indicated Resident 33 was fully clothed with her shoes on at the time of the fall, and was incontinent of urine. The clinical record did not contain an Interdisciplinary Team (IDT) note for the 2/24/25 fall. A Significant Change MDS assessment,	F 0689	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 33 and resident 68 fall events have been reviewed to ensure a root cause analysis has been completed and fall interventions implemented. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents who have a fall have the potential to be affected by the alleged deficient practice. Residents who have fallen in the last 30 days have been audited to ensure root cause analysis was completed and fall interventions implemented. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nurse managers were educated regarding the fall policy to include	06/06/2025

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	completed on 2/27/25, indicated she was sometimes able to make herself understood and sometimes able to understand what was said to her. She had moderate visual impairment, and poor decision-making skills. She was frequently incontinent of bowel and blader, and dependent on toileting. She was able to walk 150 feet with supervision/touching assistance of staff. She had a history of two falls with no injuries and one fall with an injury since her prior MDS assessment. A progress note, dated 3/29/25 at 4:50 p.m., indicated Resident 33 was found lying on the floor of another resident's room sleeping. An event report, dated 3/29/25, indicated she was fully dressed and not incontinent. An IDT note, dated 3/31/25, indicated "root cause analysis of the fall was resident was found lying on the floor sleeping in another resident room. Resident was unable to provide details of events r/t [related to] cognition. Resident self ambulates/wanders throughout unit with staff monitoring. Immediate intervention: Resident was assessed by unit nurse; vs [vital signs] and neuro [neurological] monitoring initiated; no injuries noted at the time of assessment. The resident was assisted from the floor by two staff members and provided with ADL [Activities of Daily Living] assistance. Heightened monitoring by staff. Intervention initiated by IDT: Staff to offer resident to take nap in between meals as she allows." A progress note, dated 4/27/25 at 12:47 p.m., indicated Resident 33 was found lying supine (on her back). An event report, dated 4/27/25, indicated Resident		the completion of a root cause analysis and implementation of fall interventions. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON or designee will audit 5 falls to ensure a root cause analysis is completed and interventions implemented. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	

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	33 was ambulating near the nurses' station fully clothed, shoes were on, and she was not incontinent. An IDT note, dated 4/28/25, indicated "Root cause analysis the resident had an unwitnessed fall. Floor nurse heard resident and went to where resident was walking/wandering and found resident lying in a supine position on the floor. The resident stated that she 'didn't see it,' Resident is a memory care resident and is not cognitively intact. Immediate intervention: Neuros initiated and within normal limits. VS [vital signs] taken, the resident was assisted x2 [times two] staff off the floor and brought out the nurse's station for further monitoring. Resident stated she did not hit her head. All vitals were checked again and WNL [within normal limits]. Ice was placed for 20 min on and off per hospice. Intervention initiated by IDT: Assess [Resident 33's] footwear for proper fitting." A progress note, dated 5/1/25 at 8:46 a.m., indicated Resident 33 was found lying on the floor of the activities room after an unwitnessed fall. An event report, dated 5/1/25, indicated the resident was fully clothed with shoes on and was incontinent of urine and bowel. An IDT note, dated 5/2/25, indicated " ...Root cause analysis: Resident ambulating on unit when fall occurred. Resident stands and ambulates at will. Noted with impaired safety awareness secondary to dementia, resident difficult to redirect at times. Immediate intervention: resident was assessed by unit nurse; vs and neuro monitoring initiated; no injuries noted at the time of assessment. resident [sic] was assisted from floor by staff and provided with ADL assistance.			

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	heightened [sic] monitoring and resident education provided. Intervention initiated by IDT: resident care planned for injury prevention, Care plan reviewed, continue with current plan of care." During an interview on 5/8/25 at 10:51 a.m., the Memory Care Coordinator (MCC) indicated Resident 33 would pace the unit most days. When Resident 33 appeared to be tired, staff attempted to lay her down for a nap. Some days Resident 33 would take a nap and other days she would get up and start pacing the unit again. During an interview on 5/8/25 at 12:48 p.m., the Director of Nursing (DON) indicated during IDT meetings the team looked at what Resident 33 was doing at the time of the falls. He indicated Resident 33 was impulsive and had impaired safety awareness. The DON indicated the IDT did look at root cause analysis for all falls. During an interview on 5/12/25 at 2:29 p.m., the DON and Corporate Nurse Consultant (CNC) both indicated the IDT notes were the root cause analysis of the falls. The DON indicated Resident 33 was not interviewable, and he did not feel the IDT team could speculate on what had occurred between the last time she was seen by staff and when she was found after an unwitnessed fall. The root cause analysis in the IDT notes for Resident 33 reflected the way Resident 33 was found after her fall events. A policy titled "Clinical- Fall Prevention Policy and Procedure", dated May 2016, was provided by the Executive Director (ED) on 5/7/25 at 1:36 p.m. The policy indicated " ...Purpose: The purpose of this policy is to provide [Name of Corporation] communities with best practices and evidence-based approaches to prevent falls and			

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	protect residents who are at risk for falling ...Procedure: This section describes the process for the prevention of falls and accurate documentation when there is a fall. Accurate documentation of fall risks and falls provided a clinical picture of a resident and in utilized in developing their plan of care. It is the responsibility of the interdisciplinary team to document falls prevention, when a fall occurs, and interventions to avoid future falls ... Step Two: Fall Event Assessment: The fall event assessment will be completed by the charge nurse if a patient experiences a fall. This data will be utilized by the community to thoroughly investigate the root cause for each fall and ensure effective interventions are put into place to prevent additional falls ...Step Three: Strategies of Prevention ...Each fall risk factor is unique for every resident ...Step Five: Interdisciplinary Guidelines: If a fall occurs, the interdisciplinary team [IDT] will meet collectively and examine the fall using the following criteria ... An IDT member/designee will physically visit the place of the fall to verify the post fall assessment and investigate for any for any additional information that could be useful in preventing a reoccurrence; iii. A root cause analysis will be performed utilizing the "5 Whys" CarDon process; iv. A member/designee of the IDT will assist the team and update the care plan and the nurse aide assignment sheets to ensure accuracy of fall preventions .... vi. A narrative IDT note will include: a. Root cause explanation with new intervention strategy to prevent reoccurrence ...". A policy titled "5 whys Policy", dated February 2015, was provided by the ED on 5/9/25 at 12:42 p.m. The policy indicated "Purpose: The 5 Whys is a system that is utilized to help determine the root cause of a problem. It is used to discover if a			

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	relationship exists between more than one variable and the proper use of the 5 Whys will help the user implement meaningful changes to permanently correct an identified problem. How to use 5 Whys ... 2. Complete the header questions with the resident name and identified problem being addressed. 3. Answer the first question 'why did the problem happen' and answer down below in the appropriate box. 4. Repeat step three (3) consecutively until the root cause of the problem is effectively identified ..." 2. The clinical record for Resident F was reviewed on 5/8/25 at 9:06 a.m. The diagnoses included, but were not limited to, Parkinson's disease, repeated falls, syncope (fainting) and collapse, orthostatic hypotension (a form of low blood pressure that happens when standing up from sitting or lying down), and osteoporosis (brittle bones). An Admission MDS assessment, dated 12/17/24, indicated the resident had multiple falls in the six months prior to admission, including a fall one month prior to admission to the facility. A Quarterly MDS assessment, dated 4/8/25, indicated the resident was cognitively intact. A falls care plan, dated 12/16/24, indicated Resident F was at risk for falling and fall related injuries related to requiring assistance from staff for transfers, history of falls, incontinence, using a wheelchair and walker, receiving blood pressure medication, antidepressants, syncope and collapse, and orthostatic hypotension. A physician order, dated 4/11/25, indicated the staff should encourage the resident to wear hip protectors daily as she allows. Staff were to document the completion of this task in the morning and at bedtime.			

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	155793	A. BUILDING 00 B. WING	05/12/2025

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	The Director of Nursing (DON) provided fall event reports on 5/12/25 at 11:50 a.m. They indicated the following: Resident F had an unwitnessed fall, on 4/10/25, which resulted in a bloody abrasion (scrape) to her nose. A care plan approach, initiated on 4/11/25, indicated "[Resident] to don hip protectors as she allows." Resident F had an unwitnessed fall, on 4/25/25, which resulted in a hematoma (collection of blood similar to a bruise) on her right forehead. A care plan approach, initiated on 4/28/25, indicated "Continue with plan of care." No new interventions were initiated. Resident F had an unwitnessed fall, on 5/10/25, which resulted in an abrasion and bruise to the middle of her back. The care plan approach "[Resident] to don hip protectors as she allows" was edited, on 5/6/25, to read "[Resident] to don hip protectors as she allows-refuses often." Resident F was interviewed in the physical therapy room on 5/8/25 at 10:26 a.m. She indicated she remembered seeing hip protectors in a package when she returned to her room one day. No one had put them on her before, and she had not tried them. She was observed to not be wearing hip protectors. The Unit Manager (UM) was interviewed in Resident F's room on 5/8/25 at 10:31 a.m. She was not sure where the hip protectors were and was not sure if Resident F was wearing any. She located a pair of hip protectors in plastic packaging on the floor in the resident's closet. She			

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	was going to go see if Resident F had any on. The UM was interviewed on 5/8/25 at 10:40 a.m. She indicated she had asked Resident F if she would wear the hip protectors, and the resident refused. As of 5/8/25 at 12:11 p.m., there was no documentation regarding Resident F's refusal to wear the hip protectors within the electronic health record, including but not limited to, the progress notes, event charting, observation charting, medication administration records, and/or treatment administration records. 3. The clinical record for Resident 68 was reviewed on 5/7/25 at 10:31 a.m. The diagnoses included, but were not limited to, cerebral infarction (stroke), speech/language deficits following stroke, memory deficit following cerebral infarction, and unsteadiness. An Admission MDS assessment, dated 3/7/25, indicated Resident 68 was dependent on staff for help with rolling left and right, sitting up, and transferring. A care plan, initiated on 3/6/25, indicated Resident 68 was at risk for falling and fall related injuries related to: requires assistance from staff for transfers, utilizes a wheelchair and may use walker with therapy, history of falls, incontinence, catheter in place, controls bed height and puts bed in high position despite staff explanation of risks and benefits, receives routine hypoglycemic (medicine to lower blood sugar), and PRN (as needed) narcotic use. A Post Fall Assessment note, dated 4/29/25, indicated Resident 68 had an unwitnessed fall at			

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	12:12 a.m. The following approaches were added to Resident 68's care plan, on 4/29/25, after his fall: resident sent out to emergency room for further evaluation, encourage him to leave bed height in low position that was often refused, and add bed bolsters to bed for tactile edge. Resident 68 was observed in bed on 5/5/25 at 10:38 a.m. No bed bolsters were observed on the resident's bed. Resident 68 was observed in bed on 5/7/25 at 1:36 p.m. No bed bolsters were observed in the resident's bed. There was no documentation of Resident 68 refusing the bed bolsters in his electronic health record. An interview with Registered Nurse (RN) 5 was conducted on 5/7/25 at 1:49 p.m. She indicated bed bolsters had been ordered but had not been delivered yet. An interview with the UM was conducted on 5/7/25 at 1:56 p.m. She indicated the bed bolsters had been ordered and received but Resident 68 refused them. The refusal was documented on his care plan. The care plan approach titled "add bed bolsters to bed for tactile edge" was edited, on 5/7/25, to read "add bed bolsters to bed for tactile edge-resident refused bed bolster." An interview with Resident 68's Representative was conducted on 5/8/25 at 10:44 a.m. He indicated the UM ordered the bed bolsters the			

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	day after the resident's fall. Staff came in once to put them on the bed, but Resident 68 was in pain and vomiting, so they said they would come back later. No one ever came back with the bed bolsters, and he thought they were simply forgotten. To his knowledge, Resident 68 had not refused the bed bolsters. On 5/7/25 at 1:36 p.m., the Executive Director (ED) provided a policy titled "Fall Prevention Policy and Procedure", dated May 2016. It indicated "The Community must take reasonable steps to ensure it implements best practices and evidence-based approaches to prevent falls and protect residents who are at risk for falling. Due to the risks associated with falls for older adults living in long-term care facilities, compliance with this policy is essential ...It is the responsibility of the interdisciplinary team to document falls prevention, when a fall occurs, and interventions to avoid future falls ...Every resident will be considered a high risk for falls during their stay and individual interventions will be introduced as needed for these patients...Fall risk care plans will be kept current by the IDT and other associates within each community. Individualized interventions on the fall care plan will be duplicated onto care sheets to ensure care plan strategies are integrated into the health system." 3.1-45(a)(2)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on interview and record review, the facility failed to ensure a resident had a rationale for indication of use and ongoing administration of a prophylactic antibiotic for the prevention of	F 0757	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 16, Resident L and	06/06/2025

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	urinary tract infections for 1 of 2 residents reviewed for antibiotic medications and 2 of 5 residents reviewed for unnecessary medications. (Resident 16, Resident L, and Resident 39) Findings include: 1. The clinical record for Resident L was reviewed on 5/5/25 at 11:40 a.m. The diagnoses included, but were not limited to, chronic kidney disease. A care plan, dated 12/16/24, indicated Resident L had a history of urinary tract infections. A nursing note, dated 2/13/25, indicated Resident L's Representative had requested for a prophylactic antibiotic to be given due to the resident's recurrent and history of chronic urinary tract infections. A physician order, dated 2/14/25, indicated the resident was to receive 100 milligrams of Macrobid once a day as a prophylactic for urinary tract infections. A prophylactic antibiotic care plan, dated 2/14/25, indicated the following approaches: staff were to administer antibiotic as ordered, observe for adverse reactions, and notify medical doctor if adverse reactions were observed. The February 2025, March 2025, April 2025 Medication Administration Records (MAR) indicated the staff administered the 100 milligrams of Macrobid daily as ordered. A nursing note, dated 4/10/25, indicated the medical provider ordered a urine specimen. A nursing note, dated 4/14/25, indicated the		Resident 39 have been reviewed by MD with no changes in physician's order. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents with physician's orders for prophylactic antibiotics have the potential to be affected by the alleged deficient practice and have been reviewed by the physician. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Infection Preventionist educated regarding antibiotic stewardship. Education will occur upon hire and annually. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON or designee will audit 5 residents receiving antibiotics prophylactically to ensure there is a documented rationale for indication of use and ongoing administration. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these	

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	resident's urine culture results were 10,000-50,000 klebsiella pneumoniae (bacterial infection in the urinary tract). The medical provider did not issue new orders. A nursing note, dated 4/15/25, indicated the resident was observed with increased confusion and pain. The medical provider was aware, and the staff was awaiting new orders. A nursing note, dated 4/16/25, indicated the medical provider ordered the resident to receive 400 milligrams-80 milligrams of Bactrim (antibiotic medication) twice a day for three days. A medical provider note, dated 4/16/25, indicated the resident had complaints of urinary discomfort. The staff was to administer Bactrim due to the resident being symptomatic. A physician order, dated 4/16/25, indicated the resident was to receive 400 milligrams-80 milligrams of Bactrim twice a day until 4/18/25. The April 2025 MAR indicated Resident L had received the 400 milligrams-80 milligrams of Bactrim twice a day and 100 mg of Macrobid daily as ordered, simultaneously. There was no documentation in Resident L's electronic health record regarding the rationale for continuation and ongoing use for the prophylactic antibiotic. An interview was conducted with the Director of Nursing on 5/12/25 at 8:37 a.m. He indicated the medical provider had ordered the prophylactic antibiotic for Resident L due to her chronic urinary tract infections. The medical provider did not order to stop the prophylactic antibiotic while		reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	

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	on the Bactrim antibiotic. The staff administered the antibiotics as ordered. 2. The clinical record for Resident 39 was reviewed on 5/9/25 at 11:30 a.m. The diagnoses included, but were not limited to, Alzheimer's disease and a history of urinary tract infections (UTIs). A Significant Change Minimum Data Set (MDS) assessment, dated 4/14/25, indicated severe cognitive impairment. An Acute Care Hospital After Visit Summary, dated 7/1/23, indicated Resident 39 was to start taking Macrobid (an antibiotic used to treat urinary tract infections) 100 milligrams (mg) once a day in the morning, for UTI symptoms. Resident 39 had continued to receive Macrobid 100 mg daily, since 7/1/23, for a history of frequent UTIs. There was no documentation in Resident 39's electronic health record regarding the rationale for continuation and ongoing use for the prophylactic antibiotic. During an interview on 5/9/25 at 12:39 p.m., the Infection Preventionist (IP) indicated that prophylactic antibiotics were tracked for the first month only in the Antibiotic Stewardship binder. The IP indicated antibiotics were continued as prescribed when a resident was admitted/readmitted to the facility. The IP indicated no conversation has occurred with the Medical Doctor (MD) about prophylactic antibiotic use for this resident. 3. The clinical record for Resident 16 was reviewed on 5/8/25 at 2:48 p.m. Diagnoses included, but were not limited to, benign prostatic hyperplasia (enlarged prostate gland) without urinary tract			

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	symptoms. Resident 16 was discharged from the facility's assisted living and admitted to the long-term care portion of the facility on 9/30/24. A care plan, created 10/1/24 and revised on 4/8/25, indicated "[Resident] has history of urinary tract infections. potential for recurrence." The care plan approaches indicated the following "obtain UA and C/S [urinalysis and culture/screen, two tests for urinary infection] per order ... report symptoms of UTI; concentrated and/or foul smelling urine, abdominal and/or flank pain, dysuria, fever, change in mental status ... encourage fluid intake ... assist with incontinence care as needed ..." A care plan, created on 10/1/24 and revised on 4/8/25, indicated "[Resident] is receiving antibiotic prophylactically. potential for complications." The care plan approaches indicated the following: " ...notify MD/NP should adverse reactions occur ...be alert for adverse reactions. nausea, vomiting, diarrhea, dizziness, nosebleed, insomnia ...administer antibiotic per order ..." The assisted living discharge paperwork, dated 9/30/24, indicated the resident had been prescribed Macrobid (an antibiotic used to treat urinary tract infections) prophylactically (preventatively) since 8/3/2022. A physician's order, dated 9/30/24, indicated Resident 16 was to take Macrobid 100 milligrams (mg) daily. The order had no end date. A physician admission note, dated 10/1/24, indicated the following: "Res [resident] has [Benign Prostatic Hyperplasia] BPH [enlarged prostate] with history of recurrent UTI [urinary tract infection] chronically on Macrobid 100 mg daily ...Benign prostatic hyperplasia, unspecified			

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	whether lower urinary tract symptoms present ...Denies difficulty emptying his bladder with history of recurrent UTI chronically on Macrobid ..." A note titled "Infection Tracker with McGeer's Criteria" was written on 10/1/24 at 9:10 a.m. It indicated "Admitted on ppx abx [prophylactic antibiotic] for recurrent UTIs." A review of the provider's notes from 10/1/24 to present indicated there was no rationale documented for continuing the antibiotic. The Infection Preventionist (IP) was interviewed on 5/9/25 at 12:39 p.m. She indicated they list the month a resident starts an antibiotic in their antibiotic stewardship binder but do not track residents who are on a prophylactic antibiotic. They only monitor antibiotics for new infections. The Director of Nursing was interviewed on 5/9/25 at 12:41 p.m. He indicated the provider made all decisions regarding prophylactic antibiotics and the rationale was based on their judgment. They do not give any education to their providers regarding antibiotic stewardship necessarily, but they did have an informational binder with training in it. He did not know who originally prescribed Resident 16's Macrobid. They don't always receive that information from the hospital or prior facility. They don't track antibiotic side effects, indications, etc., because that was up to the doctor's judgment and it would be documented in their notes. The ED provided a policy titled "Infection Prevention and Control Program on 5/9/25 at 12:42 p.m. It indicated "Antibiotic Stewardship. A. Culture reports, sensitivity data, and antibiotic			

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	usage reviews are included in surveillance activities. B. Medical criteria and standardized definition of infections are used to help recognize and manage infections. C. Antibiotic usage is evaluated, and practitioners are provided feedback on reviews." 3.1-48(a)(1) 3.1-48(a)(3) 3.1-48(a)(4)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview, and record review, the facility failed to ensure food was served at a palatable temperature for 14 of 14 residents reviewed for food. (Residents D, F, G, H, J, N, O, Q, R, T, X, 84, Z, and DD) Findings include: 1. The clinical record for Resident DD was reviewed on 5/6/25 at 11:00 a.m. The diagnoses included, but were not limited to, cellulitis. During an interview with Resident DD on 5/6/25 at 11:03 a.m., she indicated the food was delivered cold. 2. The clinical record for Resident 84 was reviewed on 5/5/25 at 11:15 a.m. The diagnoses included, but were not limited to, hypertension. An interview was conducted with Resident 84 on 5/5/25 at 11:37 a.m. She indicated the food was often served cold. 3. The February 2025, March 2025, and April 2025 resident council minutes were provided by the	F 0804	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents D, F, G, H, J, N, O, Q, R, T, X, 84, and Z were observed for adverse effects related to the alleged deficient practice. Residents did not experience any adverse effects. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents who eat meals served in the rehab dining room have the potential to be affected by the alleged deficient practice. The residents have been audited to ensure they have not experienced any adverse effects. 3 What measures will be put into place and what systemic	06/06/2025

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	Executive Director (ED) on 5/6/25 at 1:24 p.m. The attendees in the meetings included, but were not limited to: Resident R, Resident Z, Resident X, Resident F, Resident N, Resident H, Resident T, Resident Q, Resident D, Resident J, Resident G, and Resident O. The resident council had voiced concerns regarding dietary in February 2025 and March 2025. The food was served cold. On 5/8/25 at 12:53 p.m., a test tray was delivered from the serving station on the 600 hall after all residents from the hall received their room trays. The temperatures of the items on the test tray were obtained by the Dietary Resource Manager (DRM). Four slices of pizza were at temperatures of 110 degrees Fahrenheit (F), 127 degrees F, 131 degrees F, and 134.9 degrees F. Two sides of blackberry cobbler were at temperatures of 99.4 degrees F and 110 degrees F. During an interview on 5/8/25 at 12:58 p.m., the DRM indicated holding temperatures should be at least 135 degrees. A Food Preparation and Safety Policy, dated 2012, was provided by the Director of Dining Services on 5/9/25 at 12:34 p.m. It indicated " ...Trays are delivered promptly to ensure that food is served at a preferable temperature and to preserve the quality of the food ..." 3.1-21(a)(2)		changes will be made to ensure that the deficient practice does not recur? Dietary associates were educated on the Food Preparation and Safety Policy. Education will occur upon hire and annually. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Dietary Manager or designee will audit food temperatures in the rehab dining room food is served at a palatable temperature. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	
F 0805 SS=D Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs Based on observation, interview, and record review, the facility failed to serve a diet, as ordered by the physician, for 1 of 1 resident	F 0805	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	06/06/2025

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	randomly observed for dining (Resident 16). Findings include: The clinical record for Resident 16 was reviewed on 5/5/25 at 12:45 p.m. The diagnoses included, but were not limited to, dysphagia (difficulty swallowing). A physician's order, dated 12/20/24, indicated he was to receive a mechanically altered diet with ground meat. A care plan, last reviewed on 4/8/25, indicated he was noted with dysphagia and had the potential for complications. The goal was for him not to demonstrate dysphagia related complications such as weight loss, signs and symptoms of aspiration pneumonia, or dehydration. The interventions included, but were not limited to, providing diet per physician's order with thin liquids. On 5/5/25 at 12:45 p.m., Resident 16 was observed sitting at a table in the dining room waiting for his meal. A staff member set a plate in front of him with a Ruben sandwich, tossed salad, and root vegetables on the plate. Another staff member came up behind Resident 16 and removed his plate, taking it back to the serving area. At 12:54 p.m., Resident 16 received another plate of food which contained ground meat, root vegetables, and a tossed salad. Resident 16's meal ticket indicated he was to receive a mechanical soft with ground meat diet. During an interview on 5/6/25 at 8:49 a.m., the Director of Dining Services indicated a tossed salad should not have been served to Resident 16, because the lettuce was not shredded.		Resident 16 was observed for adverse reactions related to the alleged deficient practice and did not experience any. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents with altered diets have the potential to be affected by the alleged deficient practice and have been audited to ensure they are served a diet per physician's orders. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing associates were educated on serving residents diets per physician's order to include appropriate food selections for mechanically altered diets. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON or designee will audit meal service to ensure diets are served per physician's order. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these	

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	On 5/6/25 at 8:49 a.m., the Director of Dining Services provided the Mechanical or Dental Soft Diet guidelines which indicated "...Foods not allowed...raw vegetables except shredded lettuce..." 3.1-21(a)(3)		reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure the use of beard restraints by dietary staff, separate storage of a personal lunch bag, ensure coverage of stored frozen food and ready-to-eat dessert, and distribution of food under sanitary conditions. This had the potential to affect 96 of 96 residents in the facility. Findings include: A kitchen tour was conducted, on 5/5/25 at 9:30 a.m., with the Cook Supervisor (CS). Dietary Aide (DA) 9 was observed in the kitchen without the use of a beard restraint to cover his facial hair and instead was wearing a surgical mask below his chin. An observation of the walk-in freezer was made during the tour. Four bowls of uncovered chocolate ice cream were observed on a tray. A personal lunch bag was observed sitting on a rack within the freezer. An observation of the main dining room was conducted on 5/5/25 at 12:24 p.m. Plates of dessert	F 0812	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Associate placed beard guard on immediately during the survey, personal lunch bag was removed during the survey, and frozen foods were disposed of during the survey. Residents did not experience any adverse effects related to the alleged deficient practices. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents residing in the facility have the potential to be affected by the alleged deficient practice and have been audited to ensure they have not experienced any adverse reactions. 3 What measures will be put	06/06/2025

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	cakes were observed uncovered sitting on a cart, partially stacked on top of one another. During an interview with the CS on 5/5/25 at 11:59 a.m., she indicated she was told DA 9 could wear a surgical mask in place of a hair net to cover his facial hair. The CS also indicated that the uncovered ice cream should have been disposed of the day before, and the personal lunch bag contained ice cream samples a vendor had delivered. A Personal Hygiene for Dietary Staff Policy, revised 8/1/24, was provided by the Director of Dining Services (DDS) on 5/9/25 at 12:34 p.m. It indicated " ... Associates involved in storing, preparing, distributing, and serving food to residents shall: ...2. Wear a hair restraint that effectively covers all hair and/or facial hair (mustache, sideburns, and/or beard, to prevent contamination of food, equipment, and utensils ..." A Food and Non-Food Storage Policy, revised 2012, was provided by the DDS on 5/9/25 at 12:34 p.m. It indicated " ... All opened foods are covered to protect from contaminates ..." 3.1-21(i)(3)		into place and what systemic changes will be made to ensure that the deficient practice does not recur? Dietary associates were educated on personal hygiene for dietary staff policy and food and non-food storage policy. Education will occur upon hire and annually. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Administrator or designee will observe the dietary staff to ensure beard restraints are utilized, personal items are not stored in the kitchen, food items are covered and distributed appropriately. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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	Based on observation, interview, and record review, the facility failed to ensure staff donned a gown prior to administering medication using a nasogastric tube (nasal feeding tube), and prior to urinary catheter and colostomy care for residents on enhanced barrier precautions (EBP) for 1 of 1 resident reviewed for tube feedings and 1 of 1 resident randomly observed during care. (Resident 54 and Resident 210). Findings include: 1. The clinical record for Resident 210 was reviewed on 5/7/25 at 9:30 a.m. The diagnoses included, but were not limited to, dysphagia (difficulty swallowing) and pressure ulcer. On 5/9/25 at 1:57 p.m., Licensed Practical Nurse (LPN) 3 was observed administering medication to Resident 210. LPN 3 prepared the medication at the medication cart and entered the room. She performed hand hygiene and donned disposable gloves, attached the syringe to the nasogastric tube, and administered the medication. LPN 3 then flushed the nasogastric tube with 20 milliliters of water and reconnected the nasogastric tube to the tube feeding. She did not don a gown prior to administering the medication through the nasogastric tube. During an interview on 5/9/25 at 2:09 p.m., LPN 3 indicated she was unsure if she needed to wear a gown while administering medications through a nasogastric tube. 2. The clinical record for Resident 54 was reviewed on 5/12/25 at 10:19 a.m. Diagnoses included, but were not limited to, diverticulosis (small pouches which form in the intestines), neuromuscular dysfunction of bladder, and urinary tract	F 0880	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 210 no longer resides in the facility Resident 54 was reviewed for any changes of condition and adverse reaction related to the alleged deficient practice and did not experience any. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents with medical devices have the potential to be affected by the alleged deficient practice. An audit was conducted to ensure that residents did not have any adverse reactions to the alleged deficient practice. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing associates educated on the enhanced barrier precautions policy. Education will occur upon hire and annually. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON or designee will observe 5 associates performing care for	06/06/2025

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	infection. A Quarterly Minimum Data Set (MDS) assessment, dated 3/11/25, indicated Resident 54 was cognitively intact and had an indwelling urinary catheter and an ostomy (external bag to collect liquid stool from the intestines). A physician order, dated 2/28/25, indicated Resident 54 was on enhanced barrier precautions. A care plan, created 11/5/24 and revised 3/30/25, indicated Resident 54 required enhanced barrier precautions related to her indwelling medical device (i.e. catheter). An interview was conducted with Resident 54 on 5/5/25 at 11:38 a.m. She indicated staff always wore gloves when performing her personal care but had never seen them put on a gown. A red Enhanced Barrier Precaution sign was observed on the wall outside the resident's bathroom. A resident representative was interviewed on 5/5/25 at 11:40 a.m. She indicated she had never seen staff put on a gown when assisting Resident 54. An observation of catheter and colostomy care was conducted with Certified Nurse Aide (CNA) 7 on 5/7/25 at 9:21 a.m. CNA 7 did hand hygiene and donned gloves prior to emptying Resident 54's colostomy bag but did not don a gown. She removed her gloves prior to leaving the room to retrieve perineal (genital area) cleaner spray. When she returned to the room, she put on a new pair of gloves but did not don a gown. She then emptied Resident 54's urine catheter bag and performed catheter care on the resident.		residents with medical devices to ensure the EBP policy is followed. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 5 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	

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	An interview was conducted with CNA 7 on 5/7/25 at 9:45 a.m. She indicated she needed to don gloves only when doing perineal or catheter care. If a resident was in enhanced isolation, a cart with gowns, masks, and face shields would be outside the resident's door. The Executive Director (ED) provided a policy titled "Enhanced Barrier Precautions Policy and Procedure," created 10/2017 and revised 4/2024, on 5/12/25 at 10:21 a.m. It indicated "Enhanced Barrier Precautions [EBP] refers to an infection control intervention designed to reduce transmission of Multidrug-resistant Organisms [MDROs]. EBP employs targeted gown and glove use during high contact resident care activities. EBP is used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing ...For residents for whom EBP are indicated, EBP is employed when performing high contact, bundled Resident care activities such as dressing, bathing/showering/transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care." 3.1-18(b)(2)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00444953. Survey dates: May 8, 9 and 12, 2025	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	

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	Facility number: 012644 Residential Census: 70 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 15, 2025.		This provider respectfully requests that this SOD Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.	
R 0055 Bldg. 00	410 IAC 16.2-5-1.2(y)(1-4) Residents' Rights - Deficiency Based on interview and record review, the facility failed to ensure residents had privacy regarding their personal belongings for 3 of 5 residents reviewed for missing items. (Resident 47, Resident 37, and Resident 6) Findings include: 1. The clinical record for Resident 47 was reviewed on 5/8/25 at 3:30 p.m. The diagnoses included, but were not limited to, pain, anxiety disorder, expressive language disorder, and tremor. An interview conducted with Resident 47, on 5/8/25 at 10:50 a.m., indicated there was an instance when housekeeping staff went in to clean her apartment. The housekeeping staff went into her bedroom, shut the door, and proceeded to sweep the floor. Resident 47 indicated "that was odd" to close the door to the bedroom while sweeping, but she was sitting in the living room when this occurred. It was taking the housekeeping staff a long time to sweep the floor with the bedroom not being that big. Resident 47 indicated she had to use the bathroom and so, she proceeded to open the bedroom door to access	R 0055	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 36, resident 37 and resident 6 were interviewed and did not report any missing items. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents residing in the facility have the potential to be affected by alleged deficient practice and have been audited to ensure privacy during regarding their personal belonging 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Housekeeping staff were educated on resident privacy. Education will	06/06/2025

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	the bathroom and saw the housekeeping staff rummaging through her personal items with the drawers to her dresser open. Resident 47 indicated she reported the incident to staff, and she had not seen that housekeeping staff since then. Resident 47 didn't believe any items were missing. 2. The clinical record for Resident 37 was reviewed on 5/8/25 at 3:45 p.m. The diagnoses included, but were not limited to, cellulitis, edema, and anxiety disorder. An interview conducted with Resident 37, on 5/8/25 at 10:38 a.m., indicated she believed a facility staff member/housekeeper went through her personal items. When Resident 37 returned to her apartment, a couple of months ago, she found her stuff in "disarray", and it appeared someone went through her personal items while they were cleaning her apartment. Resident 37 reported the concern to the facility staff, and she has not seen that staff member since she reported the incident to the head nurse. 3. An incident reported to the Indiana Department of Health (IDOH), dated 12/9/24, indicated Resident 6 expressed a concern about a missing watch and believed Housekeeper 30 took the watch. The investigative file included a typed statement for Resident 6 dated 12/9/24. The statement indicated "when [Name of Housekeeper 30] came into her apartment on 12/3, [Name of Housekeeper 30] had said that she was going to clean her bedroom first. [Name of Resident 6] stated that [Housekeeper 30] had shut the bedroom door and was vacuuming for quite a long time before she left the bedroom...[Name of Resident 6] stated that she noticed her watch was missing off of her		occur upon hire and annually. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Unit Manager/designee will interview 5 residents to ensure privacy is maintained regarding their personal belongings. Audits will occur daily x 30 days, then weekly x 12 weeks and monthly x 5 months.	

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	dresser beside her table later that day...." An interview conducted with Licensed Practical Nurse (LPN) 31, on 5/8/25 at 12:34 p.m., indicated she was made aware of Resident 47's concern regarding Housekeeper 30 rummaging through her personal items. Housekeeper 30 was brand new to the position and completed orientation not too long before this allegation came up. There was another resident who complained about missing pearls that had been in the family for generations. This allegation came up during the time Resident 47 expressed concern with Housekeeper 30 rummaging through her drawers. A Residency Agreement was provided by the Executive Director on 5/12/25 at 10:48 a.m. The document indicated, under Community's Obligations, the Community will be respectful of Resident(s) right to privacy.			
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on observation, interview, and record review, the facility failed to ensure a resident who wasn't safely able to self-administer medications, did not have medications stored in their apartment for 1 of 5 residents observed for medication administration. (Resident 48) Findings include: The clinical record for Resident 48 was reviewed on 5/8/25 at 2:35 p.m. The diagnoses included, but were not limited to, hypertension, severe dementia with anxiety, and depression. A current physician order, dated 10/30/24,	R 0216	1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 48 was observed for adverse reactions related to the alleged deficient practice and did not experience any. 2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents that require medication assistance have the potential to	06/06/2025

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	indicated nursing staff was to administer medications. An observation and interview were conducted with Resident 48 on 5/8/25 at 11:00 a.m. Resident 48's door was open to her apartment and there was a bottle of Tylenol located on her dining table and three bottles of medications on her kitchen counter, around her sink. The three bottles were labeled as Pepcid, Aleve, and Delsym syrup. Resident 48 indicated her stomach was hurting and was going to inquire about taking something for it and picked up the bottle of Tylenol from her dining table to see what it was. Resident 48 did not have a current physician order for the use of Pepcid, Delsym syrup, or Aleve. An interview was conducted with Licensed Practical Nurse (LPN) 31 on 5/8/25 at 12:24 p.m. She indicated Resident 48 does not self-administer any of her medications. LPN 31 indicated she would go up to Resident 48's apartment and check on it. An interview was conducted with LPN 31 on 5/8/25 at 12:35 p.m. She indicated she had a conversation with Resident 48's daughter in the past about bringing in over-the-counter medications for the resident. LPN 31 indicated two of the four bottles expired in 2017, but she removed the bottles from Resident 48's apartment. A policy titled "Medication Administration", revised May 2012, was provided by the Executive Director on 5/12/25 at 10:48 a.m. The policy indicated that the residents have a right to self-administer medication unless the Interdisciplinary Care Plan Team of the facility determines that this practice was unsafe.		be affected by the alleged deficient practice and have been audited to ensure that medications are not stored in possession of the resident. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses educated regarding medication storage for residents that require assistance. Education will occur upon hire and annually. 4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON or designee with audit 5 residents to ensure medications are not stored in residents' rooms that are not deemed appropriate for self-administration. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure the use of beard restraints by dietary staff, separate storage of a personal lunch bag, coverage of stored frozen food and ready-to-eat dessert, and distribution of food under sanitary conditions. This had the potential to affect 70 of 70 residents in the facility. Findings include: A kitchen tour was conducted, on 5/5/25 at 9:30 a.m., with the Cook Supervisor (CS). Dietary Aide (DA) 9 was observed in the kitchen without the use of a beard restraint to cover his facial hair and instead was wearing a surgical mask below his chin. An observation of the walk-in freezer was conducted during the tour. Four bowls of uncovered chocolate ice cream were observed on a tray. A personal lunch bag was observed sitting on a rack within the freezer. During an interview with the CS on 5/5/25 at 11:59 a.m., she indicated she was told DA 9 could wear a surgical mask in place of a hair net to cover his facial hair. The CS also indicated that the uncovered ice cream should have been disposed of the day before, and the personal lunch bag contained ice cream samples a vendor had delivered. A Personal Hygiene for Dietary Staff Policy, revised 8/1/24, was provided by the Director of Dining Services (DDS) on 5/9/25 at 12:34 p.m. It indicated " ... Associates involved in storing,	R 0273	5 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Associate placed beard guard on immediately during the survey, personal lunch bag was removed during the survey, and frozen foods were disposed of during the survey. Residents did not experience any adverse effects related to the alleged deficient practices. 5 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents residing in the facility have the potential to be affected by the alleged deficient practice and have been audited to ensure they have not experienced any adverse reactions. 5 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Dietary associates were educated on the personal hygiene for dietary staff policy and food and non-food	06/06/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMILTON TRACE OF FISHERS	11851 CUMBERLAND RD FISHERS, IN 46037

(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
	preparing, distributing, and serving food to residents shall: ...2. Wear a hair restraint that effectively covers all hair and/or facial hair (mustache, sideburns, and/or beard, to prevent contamination of food, equipment, and utensils ..." A Food and Non-Food Storage Policy, revised 2012, was provided by the DDS on 5/09/25 at 12:34 p.m. It indicated " ... All opened foods are covered to protect from contaminates ..."		storage policy. Education will occur upon hire and annually. 5 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Administrator or designee will observe the dietary staff to ensure beard restraints are utilized, personal items are not stored in the kitchen, food items are covered and distributed appropriately. Audits will occur daily x 30 days, weekly x 12 weeks, then monthly for 6 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee.	