STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00427360 and IN00427339. This visit was in conjunction with a Recertification and State Licensure Survey which included the Investigation of Complaints IN00425622, IN00424692, IN00406737, and IN00406679. Complaint IN00427360 - Federal/state deficiencies related to the allegations are cited at F677 and F689. Complaint IN00427339 - Federal/state deficiencies related to the allegations are cited at F584, F677, F686, and F880. Complaint IN00425622 - Federal/State deficiencies related to the allegations are cited at F584. Complaint IN00406737 - Federal/State deficiencies related to the allegations are cited at F584 and F880. Complaint IN00406679 - Federal/State deficiencies related to the allegations are cited at F755. Complaint IN00424692 - No deficiencies related to the allegations are cited. Survey dates: January 24, 25, 26, 29, and 30, 2024 Facility number: 012466 Provider number: 155786 AIM number: 201014060 Census Bed Type: SNF/NF: 109	F 0000	br=""> This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. br=""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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Mimms	RDCS	02/23/2024

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

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	SNF: 23 Total: 132 Census Payor Type: Medicare: 10 Medicaid: 81 Other: 41 Total: 132 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 1, 2023			
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;			

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	§483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation and interview, the facility failed to ensure a clean, comfortable, and homelike environment for Residents F and G, and the potential to affect all 37 residents that reside on the memory care unit (MCU). Findings include: 1. An observation conducted on the MCU, on 1/25/24 at 10:39 a.m., of 2 residents sitting in dining room chairs in the hallway outside of the dining room. There were no couches, benches, or other lounge chairs located within the hallways on the MCU. Another observation conducted on the MCU, on 1/26/24 at 1:42 p.m., of 3 residents sitting in the hallway in dining room chairs. There was a total of 5 chairs located within the hallway outside of the dining room.	F 0584	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - dining room chairs have been removed from the memory care hallway. New benches ordered to provide additional appropriate seating for residents on the memory care unit. - the brown streak on the wall adjacent to the beds of Resident F and resident G has been cleaned How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	02/22/2024

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	Another observation conducted on the MCU, on 1/26/24 at 3:29 p.m., of 3 residents sitting in the hallway in dining room chairs. There was a total of 5 chairs located in the hallway outside of the dining room. An interview conducted with the Regional Director of Clinical Care, on 1/26/24 at 3:28 p.m., indicated they believe the MCU is too tight within the common areas. It potentially funnels the residents and the residents become too close to one another. There have been discussions about tearing down that partial wall on the MCU. It appeared that the dining room was not big enough to accommodate all the residents on the MCU. An observation conducted on the MCU, on 1/29/24 at 10:14 a.m., of 4 dining room chairs located in the hallway outside of the dining room with one resident sitting in such chair. An interview conducted with Social Services Director Float, on 1/29/24 at 2:21 p.m., indicated she floats to different facilities, specifically ones that contain a MCU. She mentioned that she submits a report to the corporation in regard to items that she had noticed. She indicated that she had noticed a lack of color, lack of pictures/decorations on the walls, and she was then going to mention the dining room chairs. The residents on the MCU will take the dining room chairs and place them back in the hallway after the facility staff places them back in the dining room. The Social Services Director Float indicated she even put a dining room chair towards the end of the hallway to allow for residents to sit down further down the hallway. This would also give the residents an opportunity to sit down on other parts of the MCU along with staff to redirect them		action(s) will be taken; - all residents have the potential to be affected by this alleged deficient practice - dining room chairs have been removed from the memory care hallway. New benches ordered to provide additional appropriate seating for residents on the memory care unit -Education provided to all staff by the Executive Director by 2/22/24 on providing a clean, comfortable and homelike environment to all residents - the brown streak on the wall adjacent to the beds of resident f and resident g has been cleaned. - an audit has been performed on all resident rooms by customer care representatives to ensure room cleanliness and a homelike environment are being provided What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; - Education provided to all staff by the Executive Director by 2/22/24 on	

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	away from other residents, if needed. 2. An observation conducted on 1/25/24 at 11:13 a.m., of a brown streak running down the wall adjacent to the beds of Resident F and Resident G. An observation conducted on 1/26/24 at 1:40 p.m., of a brown streak running down the wall adjacent to the beds of Resident F and Resident G. An observation conducted on 1/29/24 at 10:14 a.m., of a brown streak running down the wall adjacent to the beds of Resident F and Resident G. An interview conducted with Family Member 30, on 1/29/24 at 2:25 p.m., indicated they hanged fly strips on the walls adjacent to Resident F and Resident G's bed. It was possibly the adhesive from the fly strips that caused the brown streaks along the walls. The fly strips were removed approximately a month ago because "they were so disgusting". An interview conducted with Interim Director of Nursing Services, on 1/29/24 at 1:40 p.m., indicated there was no policy regarding environment. The expectations are to follow the regulations for a safe, comfortable, and homelike environment. This citation relates to Complaints IN00427339, IN00425622 and IN00406737. 3.1-19(f)(5)		providing a clean, comfortable and homelike environment to all residents - dining room chairs removed from the memory care hallway and new benches ordered to provide additional appropriate seating - brown streak on the wall has been removed and cleaned - Memory Care Support Specialist/designee will inspect the halls daily to ensure that dining room chairs are not in the hallway - audits to be conducted daily by customer care representatives to ensure room cleanliness and an homelike environment are being provided How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. CQI tool identified as F-584 will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.	

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			If Threshold of 100% is not met, an action plan will be developed to ensure compliance.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living (ADLs) received the necessary assistance needed for showering at least twice weekly as preference by a resident for 1 of 4 residents reviewed for ADLs. (Resident Q) Findings include: The clinical record for Resident Q was reviewed on 1/29/24 at 12:10 p.m. Resident Q's diagnoses included, but not limited to, chronic kidney disease, Rheumatoid arthritis, congestive heart failure, generalized muscle weakness, and low back pain. An interview conducted with Resident Q on 1/25/24 at 10:18 a.m. indicated, they weren't receiving showers at least twice weekly. They also indicated, they preferred having a shower over a complete bed bath. A significant change MDS (Minimum Data Set) completed on 5/28/23 indicated, when asked "how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?", they answered "Very important".	F 0677	**1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident unknown due to complaint, therefore no resident identifier given. (Resident Q) Resident shower preferences were reviewed, and residents are receiving shower per resident preference. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to affected by the alleged deficient practice. All residents to be interviewed for shower/bathing preferences by IDT, bathing preferences will be updated in the profile and plan of care. All residents plans of care to be reviewed and reflective of preferences regarding bathing.	02/22/2024

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	A Quarterly MDS dated 12/12/23 indicated, Resident Q required substantial/maximal assistance with showers and ability to bathe self. Resident Q's care plan dated 2/7/23 indicated, the resident required assistance with ADLs. Interventions included, but not limited to, assist with bathing, as needed, per residents preference and to offer a shower two times per week and a partial bath in between. Resident Q's electronic health record, under point of care services indicated, for December 2023 and January 2024, they received a shower on the following dates: 12/7/23 12/11/23 12/21/23 1/1/24 1/8/24 Resident Q's shower sheets provided by RDCC (Regional Director of Clinical Care) on 1/29/24 at 2:33 p.m. indicated, for December 2023 and January 2024, they received a shower on the following dates: 12/11/23 12/21/23 12/25/23 1/8/23 An interview with RDCC conducted on 1/29/24 at 2:49 p.m. indicated, residents should get showers and/or bed baths per their preference. A "Preferences for Customary Routine and Activities" observation was to be completed on admission and each resident should have a care plan for preferences. The facility was unable to provide an ADL policy		**1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** All nursing staff to be educated regarding shower schedules and resident specific preferences. Nursing management to review shower sheets daily to ensure bathing preferences are being met. **1.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?** Nursing management to review shower sheets daily to ensure bathing preferences are met and showers given per preference. Bathing/Showers QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is maintained. The Regional Clinical Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review,	

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	per RDCC on 1/29/24 at 3:42 p.m. This tag relates to Complaints IN00427339 and IN00427360.		update, and make changes to the POC as needed with input and oversight from the Regional Clinical Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide care, consistent with professional standards of practice, to prevent a stage III pressure ulcer from developing on a resident with a moderate risk for developing a pressure ulcer for 1 of 1 residents reviewed for pressure ulcers. (Resident R) Findings include: The clinical record for Resident R was reviewed on 1/26/24 at 10:42 a.m. Resident R's diagnoses	F 0686	**1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident unknown due to complaint, therefore no resident identifier given. (Resident R) All residents with skin care interventions were reviewed to ensure interventions were in place per the plan of care.	02/22/2024

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	included, but not limited to, hemiplegia (inability to move a side of body) of left dominant side; diabetes type II, generalized muscle weakness, and lack of coordination. The most current Braden Scale for Predicting Pressure Sore Risk assessment was a quarterly assessment completed by 12/28/23- 01/03/24 indicated, Resident R scored a 14 indicating, a moderate risk for the development of a pressure ulcer. Resident R's current physician orders for January 2024 as well as December 2023 physician's orders included, but not limited to, an order to have pressure reducing boots to bilateral lower extremities at all times with the exception for bathing and skin assessments and for skin assessments to be completed weekly. A care plan for Resident R initiated on 11/1/23 and last reviewed/revised on 1/17/24 indicated, Resident R was "at risk for further skin breakdown due to: Muscle weakness, Impaired mobility, Difficulty in walking, Admitted with Pressure ulcers to sacrum, incontinence of bowel and bladder, Left sided weakness due to TIA[sic, Trans-ischemic attack], AMS[sic, altered mental status]". An intervention dated 11/1/23 included, but not limited to, " Pressure reducing boot to BLE[sic, bilateral lower extremities] at all time[sic]. May [sic] removed for skin assessment and bathing. An observation of Resident R conducted on 1/25/24 at 10:02 a.m. found the resident in bed without any pressure reducing boots on to either lower extremity. An observation conducted on 1/26/24 at 2:10 p.m.		**1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to affected by the alleged deficient practice. Facility-wide audit will be completed to ensure all wound care interventions in place per order and Resident Profile. Corrective action will be taken as needed. CEN/Designee will educate all nursing staff on ensuring all wound care interventions are in place per order and Resident Profile. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** CEN/Designee will educate all nursing staff on ensuring all wound interventions are in place per order and Resident Profile each shift. CARE Companions/Dept Heads/Designee will round daily to ensure wound care interventions are in place. **1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality**	

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	found Resident R lying in bed without their pressure reducing boots on their feet. The pressure reducing boots were located in Resident R's wheelchair across the room. An observation conducted on 1/29/24 at 10:38 a.m. found Resident R sitting in their wheelchair without any pressure reducing boots on their feet and legs in a dependent position. Resident R's skin assessment completed on 12/25/23 did not indicate any new skin issues. A New Skin Event dated 1/3/24 indicated, Resident R had an open area to the left lateral ankle which was draining serosanginous (thin, watery, bloody) fluid. It was described as a stage III pressure ulcer (a full thickness ulcer that might involve the subcutaneous fat) which was not present on admission and measured 2.6 cm(centimeters) in length and 2.3 cm in width. A wound assessment completed on 1/4/2024 at 9:25 a.m. indicated, the Stage III pressure ulcer on the left lateral ankle of Resident R was 2.5 cm in length and 2.3 cm in width with a depth of 0.1 cm. It indicated, the exudate was a light amount of serous fluid "(clear, amber, thin and watery)". The base of the wound was covered with 50% slough (dead tissue, usually cream or yellow in color which can harbor pathogenic organisms). A wound assessment completed on 1/9/2024 at 11:22 a.m. indicated, the stage III pressure ulcer on the left lateral ankle of Resident R was 2 cm in length and 2 cm wide. The wound did not have any exudate and described the tissue type as necrotic (death of living cells in tissue) and the wound was 100% covered by eschar (dry, thick, leathery tissue that is often tan, brown, or black).		**assurance program will be put into place?** Skin Interventions QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is maintained. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Clinical Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit.	

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	A wound assessment completed on 1/16/2024 at 12:52 p.m. indicated, Resident R's left lateral ankle wound was 2 cm in length and 2 cm in width. Exudate was a light amount of serosanginous "(pale red to pink, thin and watery)" fluid. The tissue type was described as slough and covered 100% of the wound. The comments included that measurements were unchanged but the tissue type changed from 100% eschar to 100% slough. A care plan initiated on 1/4/24 (after the identification of the new wound) and last updated on 1/27/24 indicated, Resident R "has a pressure ulcer to the left lateral ankle. Resident is at risk for further skin breakdown due to: Muscle weakness, Impaired mobility, Difficulty in walking, Admitted with Pressure ulcers to sacrum, incontinence of bowel and bladder, Left sided weakness due to TIA, AMS. Interventions in place prior to wound development include: Pressure reducing boots to BLE, turn/reposition Q 2 hours, weekly skin checks, routine bathing". This tag relates to Complaint IN00427339. 3.1-40 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices			

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	to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure fall interventions were in place for 2 of 5 residents reviewed for accidents. (Resident L and P) Findings include: 1. The clinical record for Resident L was reviewed on 1/26/24 at 11:00 a.m. The diagnoses included, but were not limited to, Alzheimer's disease with late onset, dementia, major depressive disorder, anxiety disorder, muscle weakness, and history of falling. A fall care plan, revised 1/11/24, indicated Resident L was at risk for falls and had a history of falls. She required assistance with mobility, transfers, and ambulation along with poor safety awareness. The approaches included, but were not limited to, the following: Wheelchair to be kept in a locked position at bedside when resident is in bed dated 12/26/23, Leave wheelchair at dining room entrance/exit dated 8/9/23, & Wheelchair to have anti tippers dated 6/12/23. An observation of Resident L, on 1/26/24 at 10:33 a.m., of them lying in bed with appearance of sleep. There was no wheelchair in her room. An observation of Resident L, on 1/26/24 at 1:43 p.m., of them up in a wheelchair in the hallway of the unit. There were no anti tippers to such wheelchair. An observation of Resident L, on 1/26/24 at 3:29 p.m., of them up in a wheelchair in the dining room	F 0689	**1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident unknown due to complaint, therefore no resident identifier given. All residents with fall interventions were reviewed to ensure fall interventions were in place per plan of care. **1.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All residents fall care plans to be reviewed for listed interventions. All interventions to be audited to ensure they are in place as ordered/care planned. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** All nursing staff and IDT members to be educated on fall plan of cares and interventions. Checks for fall interventions to be completed by IDT members/designee each shift. **1.How the corrective action(s)**	02/22/2024

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	during an activity. There were no anti tippers to such wheelchair. An observation of Resident L, on 1/29/24 at 10:12 a.m., of them up in a wheelchair in the dining room. There were no anti tippers to such wheelchair. An interview conducted with the Regional Director of Clinical Care on 1/29/24 at 4:35 p.m., indicated the residents on the Memory Care Unit (MCU) will move the chairs around, including the wheelchairs. The facility staff were unsure about putting residents' names in their wheelchairs for identification purposes. A policy titled "Fall Management Policy", revised 8/2022, was provided by the Interim Director of Nursing Services on 1/29/24 at 11:22 a.m. The policy indicated the following, " ...3. A care plan will be developed at time of admission with specific care plan interventions to address each resident's fall risk factors. Care plan including interventions and fall risks will be reviewed at least quarterly ...Post fall ...6. All falls will be discussed by the interdisciplinary team [IDT] at the 1st IDT meeting after the fall to determine root cause and other possible interventions to prevent future falls ...." 2. The clinical record for Resident P was reviewed on 1/24/24 at 2:22 p.m. The Resident's diagnosis included, but were not limited to, diabetes and dementia. A care plan, initiated 10/4/23, indicated Resident P was at risk for falls due to a history of falls, insomnia, anxiety and depression conditions and medications that increase fall risk. The goal was for his fall risk factors would be reduced in an attempt to avoid significant fall related injury. The interventions included, but were not limited to,		**will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** Fall Intervention QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is maintained. The Regional Clinical Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Clinical Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit.	

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	dycem (tacky plastic) underneath wheelchair cushion, initiated 10/23/23, anti-rollbacks (brakes to prevent rolling) to wheelchair, initiated 12/4/23, dump (lower the back of the seat) wheelchair, initiated 12/4/23, nonskid footwear, initiated 10/4/23, and offer and encourage him to in the dining room and common area after getting ready for the day, initiated 10/6/23. The clinical record included Fall Events with the following dates: 12/01/23, 12/4/23, 12/9/23, 12/20/23, 1/3/24, and 1/23/24. A Fall Risk Assessment Tool, dated 12/18/23, indicated he was at high risk for falls. A Quarterly MDS (Minimum Data Set) Assessment, completed 12/18/23, indicated Resident P was severely cognitively impaired, was dependent on staff for putting on and taking off footwear, needed maximum assist with transfers, and had fallen 2 or more times without injury since his last MDS assessment. On 1/24/24 at 2:22 p.m., Resident P was observed sitting in his wheelchair in his room. There were no anti-roll back brakes present on the wheelchair and the wheelchair seat was not dumped (the seat was not slanted to the back of the seat). On 1/25/24 at 9:45 a.m., Resident P was observed sitting in his wheelchair in the doorway of his room. He was wearing regular black socks and no shoes. His wheelchair did not have anti-roll back brakes and the wheelchair seat was not dumped. On 1/26/24 at 9:13 a.m., Resident P was observed sitting in the dining room. His wheelchair did not have anti-roll back brakes, there was no dycem or cushion in his wheelchair and the seat of the			

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	wheelchair was not dumped. On 1/26/24 at 10:50 a.m., Resident P's wheelchair was observed with the Float DON (Director of Nursing), who indicated that there were no anti-roll back brakes on the wheelchair, however the Float DON believed that the wheelchair Resident P had been sitting in was not wheelchair. During an interview on 1/26/24 at 11:01 a.m., the Rehab Coordinator indicated that Resident P was not in the wheelchair that he should have been in. Staff would sometimes switch out resident's wheelchairs accidentally, especially if the resident went out for an appointment. Resident P had gone to an appointment on 1/25/24. On 1/26/24 at 1:51 p.m.., the Regional Director of Clinical Care provided the Fall Management Policy, last revised 8/2022, which read "... It is the policy of ... to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related falls...Facilities must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls...Residents who are categorized as moderate to high risk should have fall interventions implemented based on resident specific risk factors..." This Federal tag relates to complaint IN00427360. 3.1-45(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and			

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	comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be			

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	the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observations, interviews and record reviews, the facility failed to properly prevent and/or contain COVID-19 by not testing a resident with signs and/or symptoms of COVID- 19 timely for 1 of 1 residents reviewed during a random observation for respiratory care. (Resident Q). Findings include: The clinical record for Resident Q was reviewed on 1/29/24 at 12:10 p.m. Resident Q's diagnoses included, but not limited to, chronic kidney disease, Rheumatoid arthritis, congestive heart failure, generalized muscle weakness, and low	F 0880	**1.What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?** Resident unknown due to complaint, therefore no resident identifier given. (Resident Q) Any resident with COVID symptoms are tested immediately to ensure transmission based precautions are implemented. **1.How will you identify other residents having the potential**	02/22/2024

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	back pain. An interview and observation were conducted with Resident Q on 1/25/24 at 10:18 a.m. During the interview, Resident Q indicated, she had been experiencing sneezing, a sore throat, congestion, and a runny nose for a couple days. During the interview, it was observed that Resident Q needed to blow her nose and did not have any facial tissue to use, so she took a piece of clothing within her reach and blew her nose into it. She then indicated, she was unable to wash her hands without assistance to get up and out of bed nor did she have any hand sanitizer to utilized within her reach. An interview with RDCC (Regional Director of Clinical Care) conducted on 1/26/24 at 10:30 a.m. indicated, Resident Q had not been tested for COVID-19 despite having signs/symptoms of COVID. RDCC indicated, any resident who exhibits any signs/symptoms of COVID-19 should have a swab test for COVID-19. RDCC further indicated, Resident Q would be re-tested for COVID-19 on day 3 of her symptoms as well. A COVID-19 policy, last revised on 7/2023, was received on 1/26/24 at 11:38 a.m. from Director of Nursing (DON). The policy indicated, "...f. Source control for residents and staff should be used in the following circumstances: i. Have suspected or confirmed COVID-19 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze)...SARS-CoV2 Viral Testing... Anyone with even with mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for COVID-19. " The Centers for Diseases and Control's (CDC) Respiratory Illness Symptoms when SARS-CoV-2		**to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to affected by the alleged deficient practice. Regional Clinical Consultant/Designee to provide education to nurse management regarding COVID-19 and policy related to testing. **1.What measures will be put into place or what systemic changes will you make to ensure that deficient practice does not recur?** Facility IP/Designee to review documentation and orders daily to identify those that need tested for COVID-19. Those that need testing are tested immediately and transmission based precautions are implemented per COVID policy and CDC guidelines. All licensed nurses to be educated on signs/symptoms of COVID and policy/CDC guidelines related to testing. **1.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?** COVID-19 Resident QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is	

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	and Influenza Viruses are Co-circulating guidance, last reviewed: November 14, 2023, from Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases (NCIRD) website, last accessed 1/31/24 at 3:44 p.m. indicated, " Place symptomatic residents in Transmission-Based Precautions using all recommended PPE for care of a resident with suspected SARS-CoV-2 infection... Because some of the signs and symptoms of influenza and COVID-19 are similar, it may be difficult to tell the difference between these two respiratory diseases based on symptoms alone. Residents in the facility who develop symptoms of acute illness consistent with influenza or COVID-19 should be moved to a single room, if available, or remain in their current room, pending results of viral testing. They should not be placed in a room with new roommates, nor should they be moved to a COVID-19 care unit (if one exists), unless they are confirmed to have COVID-19 by SARS-CoV-2 testing...Test any resident with symptoms of COVID-19 or influenza for both viruses. Because SARS-CoV-2 and influenza virus co-infection can occur, a positive influenza test result without SARS-CoV-2 testing does not exclude SARS-CoV-2 infection, and a positive SARS-CoV-2 test result without influenza testing does not exclude influenza virus infection... Placement Decisions A) Residents confirmed to have SARS-CoV-2 infection should be placed in a single room, if available, or housed with other residents with only SARS-CoV-2 infection. If unable to move a resident, he or she could remain in the current room with measures in place to reduce transmission to roommates (e.g., optimizing ventilation).		maintained. The Regional Clinical Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Clinical Consultant for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit.	

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	Residents found to have SARS-CoV-2 and influenza virus co-infection should be placed in a single room or housed with other co-infected residents. These residents should continue to be cared for using all recommended PPE for the care of a resident with SARS-CoV-2 infection. If single room isolation or cohorting of residents with SARS-CoV-2 and influenza virus co-infection is not possible, consult with public health authorities for guidance on other management options (e.g., transferring the resident; placing physical barriers between beds in shared rooms and initiating antiviral chemoprophylaxis for roommates to reduce their risk of acquiring influenza, improving ventilation by adding HEPA filters). B) Residents confirmed to have influenza virus infection only should be placed in a single room, if available, or housed with other residents with only influenza virus infection. If unable to move a resident, he or she could remain in the current room with measures in place to reduce transmission to roommates (e.g., optimizing ventilation, antiviral chemoprophylaxis for exposed roommates). Residents with influenza should be placed in Droplet Precautions, in addition to Standard Precautions. As part of Standard Precautions, eye protection should be worn if splashes or sprays are anticipated (e.g., the resident is coughing or sneezing). Because it can be difficult to anticipate potential for coughs and sneezes, facilities might consider having healthcare personnel routinely wear eye protection for the care of residents with influenza. C) Residents with symptoms of acute respiratory			

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	illness who are determined to have neither SARS-CoV-2 nor influenza virus infection should be cared for using Standard Precautions and any additional Transmission-Based Precautions based on their suspected or confirmed diagnosis." This tag relates to Complaint IN00427339 and IN00406737 3.1-18(b) 3.1-18(l)			