STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00456239 Complaint IN00456239- No deficiencies related to the allegations are cited. Survey dates: March 31, April 1, 2, 3, and 4, 2025. Facility number: 002657 Provider number: 155681 AIM number: 200308930 Census Bed Type: SNF: 44 SNF/NF 37 Total: 81 Census Payor Type: Medicare: 24 Medicaid: 24 Other: 33 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 10, 2025.	F 0000	This plan of correction is to serve as Autumn Woods Health Campus credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Autumn Woods Health Campus or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility, nor does this submission constitute an agreement or admission of the survey allegations. Attached you will find the plan of correction for Autumn Woods Health Campus annual survey that was completed on 04/04/2025. The plan of correction and specific correction actions are prepared and/or executed in compliance with State and Federal Laws. The campus' date of alleged compliance is: 04/18/2025. We initiated immediate interventions when concerns were identified during recertification survey. The facility respectfully requests from the department a desk review for substantial compliance. If you need any information or paperwork, please contact me at 812-941-9893. Sincerely, Brandy D'Angelo, Executive Director	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandy D'Angelo	Executive Director	04/18/2025

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

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F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to ensure the physician was notified in a timely manner for 1 of 5 residents reviewed for a significant change in condition. (Resident 35) Findings include: The record for Resident 35 was reviewed on 4/3/25 at 11:23 a.m. The residents's diagnoses included, but were not limited to, pleural effusion, acute respiratory syncytial virus, hypertensive heart disease with heart failure, endocarditis, dementia, cardiomegaly, and edema. The physician's order, dated 12/30/24, indicated the resident was prescribed furosemide 20 milligrams (mg) once a day for bilateral lower extremity edema. The Quarterly Minimal Data Set (MDS) assessment, dated 3/3/25, indicated the resident was moderately cognitively intact. The nurse's note, dated 12/25/24 at 3:07 p.m., indicated Resident 35 presented with pitting edema to the bilateral lower extremities. The left leg was observed to be worse with 2+ edema (4mm of depression rebounding in 15 seconds or less) and the right lower extremity had +1 edema. The resident complained of mild pain to the lower legs, and indicated the pain was worse on palpation. The resident was observed to be short of breath with some expiratory wheezes. The bilateral lower extremities were elevated. The record lacked documentation the physician was notified in a timely manner when the resident	F 0580	***F580: Notify of Changes*** ***What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** Identified resident #35 as having the potential to be affected by the cited deficiency. Resident had a change of condition R/T edema and physician was not notified at the time of occurrence. Resident remains at campus without any edema noted nor any adverse effects from the edema event. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** *All residents that currently reside in campus with a change of condition have the potential to be affected by the alleged deficiency. No findings of change of condition with untimely provider notification noted. ***What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur:**	04/18/2025

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	had a change in condition. During an interview, on 4/3/25 at 11:00 a.m., RN 3 indicated if a resident had increased edema in her extremities, shortness of breath, and pain in the extremities, she would do an assessment on the resident that included listening to the lung sounds, oxygen saturation, and vital signs. She would call the physician related to the resident's change in condition. During an interview, on 4/4/25 at 8:30 a.m., RN 4 indicated when the resident had a change in condition, staff should do an assessment and call the doctor immediately. A chest x-ray and labwork could be done. She would monitor the resident's respiratory status and elevate her lower extremities. During an interview, on 4/4/25 at 9:45 a.m., the Director of Nursing (DON) indicated the physician should have been notified when the resident had a change in condition. The review of the facility's current policy on Physician - Provider Notification Guidelines included, but was not limited to, "...To ensure the resident's physician or practitioner (may include NP, PA, or clinical nurse specialist) is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care..." 3.1-5 (a)(2)		*CS provided education to DHS/ADHS regarding timely provider notification on 04/07/2025. *DHS/ADHS provided education to licensed nurses regarding timely provider notification 04/07/2025 to 04/11/2025. *All residents currently residing in the campus with change of condition assessed for proper provider notification 04/04/2025 through 04/07/2025. No residents identified with improper notification. ***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 practice?** **DHS/ADHS or designee to verify provider documentation to ensure that all tasks completed including proper notifications for three residents as available weekly x4 weeks, then every other week x2 months, then monthly x3 months. *As a quality measure, DHS/ADHS or designee, will review any findings and corrective action at least monthly and ongoing until campus achieves one hundred percent compliance in the campus QAPI meetings. The plan will be reviewed and update as warranted.	

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			Compliance Date: 04/18/2025	
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to ensure appropriate interventions were implemented to prevent falls for 5 of 7 residents reviewed for accidents. (Residents 73, 57, 51, 55, and 12) Findings include: 1. During an interview, on 4/1/25 at 10:17 a.m., Resident 73's family member indicated when the resident was in a room on the Legacy Lane Unit, while being transferred from the wheelchair to the bed, a fall occurred. A lift chair was supposed to have been used and the Certified Nurse Aides (CNAs) decided to transfer Resident 73 from the shower to the bed in a wheelchair. There were no peddles on the wheelchair and the resident's feet dropped to the floor. When the resident's feet hit the floor, the resident fell forward from the wheelchair and the resident's face hit the floor. The wheelchair had pedals available since admission, but they were taken off by the staff. During an observation of the resident, on 4/3/25 at 10:54 a.m., the resident was sitting in a wheelchair in their room. There were foot pedals on the wheelchair and the resident had both feet resting on the pedals. During an observation, on 4/3/25 at 1:02 p.m., CNA 6 and Licensed Practical Nurse (LPN) 7 transferred the resident from the wheelchair into the recliner with a sit to stand lift. The resident	F 0689	***F689: Free of Accident Hazards/Supervision/Devices*** ***What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** Identified resident #73, #57, #51, #55, and #12 was identified as having the potential to be affected by the cited deficiency. Residents #73, #57, #51, #55, and #12 remain in facility and noted with review of care plans and updated to reflect current lift status and appropriate mobility device. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** *All resident who require the use of wheelchair for transport purposes have the potential to be affected. *All residents who require assistance with transfers had the potential to be affected.	04/18/2025

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	indicated a fear of standing at that time. The record for Resident 73 was reviewed on 4/1/25 at 1:52 p.m. The resident's diagnoses included, but were not limited to, a mechanical complication of an internal fixation device to the left femur, presence of a left artificial hip joint, localized edema, encephalopathy, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety. The Social Service note, dated 1/20/25 at 2:35 p.m., indicated the resident required a full body mechanical lift and had several family members visiting on the Legacy Lane room. The Legacy Lane Leader offered a larger accommodation to meet the resident's needs better. The resident's family agreed to change rooms. The nurse's note, dated 1/20/25 at 5:44 p.m., indicated the resident required total care. The family had been at the resident's bedside with the resident since 7:30 a.m. The resident required a full body mechanical lift for transfers. She could not change positioning in the high back wheelchair. The resident had required staff to reposition over six times on this date with no safety awareness. The care plan, dated 1/29/25, indicated the resident was at risk for falling related to decreased mobility, a history of falls, left total hip arthroplasty (THA), and dementia. The interventions, dated 3/6/25, included, but were not limited to, apply foot pedals to the wheelchair when being used for mobility. The nurse's note, dated 3/5/25 at 9:55 p.m., indicated the resident had fallen in the room. The resident had been given a shower this evening. The CNA was propelling the resident in a		***What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur:** *CS provided education to DHS/ADHS regarding transporting resident in wheelchair to utilize foot pedals and proper transfers on 04/07/2025. *DHS/ADHS provided education to licensed nurses and certified caregivers regarding transporting resident in wheelchair to utilize foot pedals on all residents that require assistance during wheelchair mobility 04/07/2025 to 04/11/2025. *100% audit of resident's requiring a wheelchair for transport to ensure foot pedals are available for use. *All residents have an updated lift evaluation completed and care plans reviewed. *DHS/ADHS provided education to licensed nurses and certified caregivers regarding proper transfers 04/07/2025 to 04/11/2025. ***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 practice?**	

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	wheelchair to the bed, when the resident put both feet down and fell forward. The resident landed on both knees and appeared to have abrasions to the forehead and upper lip, and a skin tear to the nasal bridge. The skin tear was superficial and measured 0.2 centimeters (cm) long by 0.2 cm wide. The wounds were cleaned with wound cleanser and a triple antibiotic ointment (TAO) was applied to the abrasions. Steri strips were applied to the nasal bridge. The resident complained of pain only to the facial wounds at this time. Neurological checks were initiated. The Interdisciplinary Team (IDT) note, dated 3/6/25 at 9:49 a.m., indicated on 3/5/25 around 9:55 p.m., the resident sustained a fall. The resident was being assisted from the bathroom to the bed by wheelchair, when the resident's feet fell to the floor, causing the resident to fall forward out of the wheelchair. The resident received an abrasion to the forehead, abrasion to the upper lip, and a skin tear to the nasal bridge. A therapy referral was completed. The resident sustained a fall, with new measures to be initiated. The nurse's note, dated 3/8/25 at 1:22 p.m., indicated the resident's family brought in outside assistance to work with the resident. The assistant placed the resident on the toilet. Staff were called in for assistance to help provide peri care for the resident. The resident was only able to stand for about 30 seconds before getting too weak to stand. The resident was assisted to the wheelchair and was sitting with family. The resident's family was educated on the use of a wheelchair as well. The resident kept sliding down in the wheelchair. The wheelchair was too small, and the resident needed a high back chair due to height. The resident's family continued to want to use a regular sized wheelchair. A Pommel cushion		**DHS/ADHS or designee to verify foot pedals being utilized during transport for three residents during various shifts as available weekly x4 weeks, then every other week x2 months, then monthly x3 months. **DHS/ADHS or designee to observe three residents during various shifts receiving assistance with a transfer to ensure transfer assistance is provided according to the care plan for three residents as available weekly x4 weeks, then every other week x2 months, then monthly x3 months. *As a quality measure, DHS/ADHS or designee, will review any findings and corrective action at least Monthly and ongoing until campus achieves one hundred percent compliance in the campus QAPI meetings. The plan will be reviewed and update as warranted. Compliance Date: 04/18/2025	

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	was in place. The resident continued to have scabbing and bruising to the face from the previous fall. The resident had no complaints of pain related to the fall. Staff would continue to monitor the resident. The nurse's note, dated 3/9/25 at 7:23 p.m., indicated the resident was transferred with a full body mechanical lift that shift. The outside Physical Therapist came out this shift, educated the family on lifting the resident with a mechanical lift, and indicated, if the resident could not bear weight on at least one foot, a lift must be used, and the family was in agreeance. During an interview, on 4/3/25 at 1:10 p.m., CNA 6 indicated the resident had the full body mechanical lift for transfers since 1/17/25. Two staff were always used to transfer the resident. During an interviewon 4/4/15 at 8:29 a.m., the Legacy Lane Supervisor indicated Resident 73 was ordered a full body mechanical lift in February 2025 and the order was changed to a stand-up lift on 3/7/25. When the resident got out of the shower chair, the foot pedals should have been on the wheelchair. The lift should have been used to transfer the resident at the time of the fall. During an interview, on 4/4/25 at, 8:45 a.m., Legacy Lane Leader indicated Resident 73's family called her and talked to her about the incident. The family witnessed it, and she reported it to the Director of Nursing (DON). The family indicated the resident had gotten a shower completed before the transfer. The Legacy Lane Leader didn't do the investigation into the fall. The staff were taking the resident back to bed and the foot pedals weren't on the wheelchair. The resident required a full body mechanical lift and staff			

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	should have been using the full body mechanical lift to transfer the resident back out to the bed or wheelchair. If the resident was in a wheelchair, the resident should have had the foot pedals on the wheelchair. During an interview on 4/4/25 at 9:42 a.m., the DON indicated the foot pedals were encouraged, but if the resident didn't want the bilateral foot pedals to be used for transport, then they wouldn't be applied. The resident required more extensive assistance on admission. The resident was a total mechanical lift at the time of the fall. That intervention was reviewed on 3/7/25 after the fall. The resident would have been transferred by wheelchair, but the lift should have been used for wheelchair to bed or recliner transfers. If the resident was in a wheelchair, the foot pedals should have been in place. The resident did not sustain fractures but had abrasions. 2. The record for Resident 57 was reviewed on 4/1/25 at 1:21 p.m. The resident's diagnoses included, but were not limited to, progressive supranuclear ophthalmoplegia (Steele-Richardson-Olszewski syndrome), presence of a right artificial shoulder joint, fibromyalgia, rheumatoid arthritis, severe morbid obesity due to excess calories, low back pain, pain in the left knee and right shoulder, arthritis, muscle weakness, and difficulty in walking. The care plan, dated 7/9/24 and revised 2/25/25, indicated the resident had a diagnosis of osteoporosis and was at risk for fractures and increased weakness. The interventions, dated 7/9/24, included, but were not limited to, administer medications per the physician's orders, and assist as needed with mobility.			

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	The care plan, dated 7/9/24 and revised 2/25/25, indicated the resident was at risk for falling related to altered balance and mobility. The resident needed assistance of one staff member for transfers and ambulation attempts. The interventions, dated 2/26/25, included, but were not limited to, the resident was to utilize the wheelchair for mobility. On 2/17/25 the resident was to utilize a gait belt with staff while ambulating. On 2/3/25 educate the family on the importance of safe wheelchair mobility. On 7/9/24 encourage the resident to assume standing position slowly, ensure the floor was free of liquids and foreign objects, keep the call light within reach, keep personal items and frequently used items within reach, provide non-skid footwear, staff were to assist the resident with transfers as needed, and therapy was to evaluate and treat the resident as needed. The nurse's note, dated 2/13/25 at 9:13 p.m., indicated Resident 57 was in their room ambulating with a walker, going from the bathroom to the bed with CNA assistance. The CNA stepped away to straighten linens on the resident's bed and the resident became weak and fell backwards. The fall was witnessed by the CNA and the resident did not hit their head upon the fall. The hospice company and the physician were notified. The resident complained of pain to the mid back. Urgent x-rays were ordered. The nurse was notified by the x-ray company, which indicated they would not be able to do x-rays until the following day. The IDT note, dated 2/17/25 at 7:22 a.m., indicated the fall on 2/15/25 was reviewed. The new measures taken to prevent the recurrence of the fall were for the resident to be taken to the bed. The root cause was bilateral lower extremity (BLE)			

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	weakness. The intervention put into place to address root cause of the fall was for the resident to utilize a gait belt with staff while ambulating. The nurse's note, dated 2/25/25 at 5:59 p.m., indicated the resident was ambulating from the recliner to the bathroom with the assistance of one CNA. The resident was in the bathroom doorway, going in the direction of the toilet and fell backwards towards the wall and landed sitting upright on the floor. The fall was witnessed by the CNA and the resident did not hit their head on the floor. The IDT note, dated 2/26/25 at 5:58 p.m., indicated the fall on 2/25/25 was reviewed. The resident was ambulating to the bathroom with a CNA, utilizing a walker. The new measures taken to prevent recurrence at the time of the fall was to encourage the resident to use a wheelchair for mobility. The root cause of the fall was bilateral lower extremity weakness related to the disease process progression. The intervention put in place was to utilize a wheelchair for mobility During an interview, on 4/4/25 at 9:49 a.m., DON indicated on 2/13/25 the intervention after the fall was to use the gait belt while ambulating. The nurse's note didn't say if the CNA tried to intervene with the fall on 2/13/25. The CNA should have been walking with the resident at an angle behind them. A different CNA was present on the 2/25/25 fall. The policy was that if a resident was going to fall staff would try to lower the resident slowly. She indicated the CNA present on the 2/13/25 fall was working at this time. The CNA for the 2/25/25 fall was not working at this time, but she would try to call them. Later in the day, the DON indicated she was not able to speak with the CNA.			

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	During an interview, on 4/4/25 at 10:02 a.m., CNA 8 indicated the resident was ready for bed and was ambulating back from the bathroom on 2/13/25. The resident used the walker and had a gait belt around her waist. The CNA realized the covers weren't pulled back, so she went to pull the covers back, leaving the resident standing alone. The resident had still been walking well, and the CNA went back to the resident as the resident fell but couldn't catch her. The resident hit her back, and the CNA reported the fall to the nurse. She felt that she should have stayed with the resident. 3. During an observation and interview, on 4/4/25 at 8:30 a.m., the Legacy Lane Supervisor entered Resident 51's room, where the resident was looking in the wardrobe. The Legacy Lane Supervisor pulled the resident away from the wardrobe, without the foot pedals on the wheelchair and the resident's feet were dragging as she pulled. The Legacy Lane Supervisor indicated it was more dangerous for the resident to have foot pedals on the wheelchair. The Legacy Lane Supervisor obtained the foot pedals and when the Legacy Lane Supervisor placed the foot pedals on the wheelchair, the resident asked, "What are those." The Legacy Lane Supervisor was then able to push the resident in the wheelchair down to the dining room. The record for Resident 51 was reviewed on 4/4/25 at 9:45 a.m. The resident's diagnoses included, but were not limited to, multiple fractures of ribs on the left side, dementia, and tachycardia. The care plan, dated 8/7/24 and last revised on 1/22/25, indicated the resident was at risk for falling related to weakness, decreased mobility, and recent fractures. The intervention, dated			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12/26/24, included, but was not limited to encourage the resident to use foot pedals when up in wheelchair. The Quarterly MDS assessment, dated 1/15/25, indicated the resident was severely cognitively impaired. She required substantial to maximal assistance with transfers from chair to bed or chair. 4. During an observation, on 4/4/25 at 8:23 a.m., RN 4 was pushing Resident 55 up to the dining room table for breakfast. There were no pedals on the wheelchair and the resident's right foot turned inward as the RN pushed the resident. The RN tried pushing harder, until she saw the resident's foot turned and she leaned down to turn the resident's foot into a straight position. The resident was tall, and his feet had to be placed forward away from the wheelchair. The record for Resident 55 was reviewed on 4/4/25 at 10:00 a.m. The resident's diagnoses included, but were not limited to, dementia and fractures. The Quarterly MDS assessment, dated 11/22/24, indicated the resident was severely cognitively impaired. He required total assistance for chair to bed or chair transfer. He was dependent on staff to propel the wheelchair over 150 feet. During an interview on 4/4/25 at 8:45 a.m., Legacy Lane Leader indicated Resident 55 walked in his wheelchair and he didn't need the foot pedals. His foot should not be bent back, but he could be resistant with care at times. He should have been talked through the move in his wheelchair. He liked to push backward and, in his wheelchair, and move away from the table. 5. The record for Resident 12 was reviewed on			

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	155681	A. BUILDING 00 B. WING	04/04/2025

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	4/3/25 at 8:30 a.m. The resident's diagnoses included, but were not limited to, dementia, altered mental status, weakness, repeated falls, assistance with personal care, muscle weakness, and difficulty in walking. The care plan, dated 1/29/24 and revised on 3/20/25, indicated Resident 12 was at risk for falls. The interventions included, but were not limited to, foot pedals to the wheelchair while transporting the resident in a wheelchair, dycem cushion to the wheelchair, and staff were to help with transfers as needed. The Quarterly MDS assessment, dated 12/13/24, indicated the resident was severely cognitively impaired. Resident 12 required maximal assistance with transfers and mobility. The nurse's notes, dated 7/11/24 at 10:24 a.m., indicated the resident had a decline in mobility causing the resident to be an extensive assistance of two staff members with transfers. The resident could not maintain a standing position without staff assistance when being toileted, getting out of the shower and transferring from her bed to her wheelchair. The nurse's note, dated 9/8/24 at 2:08 p.m., indicated the resident was being transported to church down Cherry Hill hallway in a wheelchair. The resident could no longer hold her feet up, and her feet hit the floor while the wheelchair was moving. The wheelchair stopped brisk, and Resident 12 slid out of the wheelchair onto the floor. During an interview, on 4/4/25 at 8:30 a.m., RN 4 indicated some of the residents thought they could still get up and care for themselves. Fall			

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	interventions included,the staff should toilet the residents every two hours or more if needed, nonskid footware, fall mats beside the bed, touch pad call lights, anti-tippers on the wheelchairs, anti-roll backs on the wheelchairs, snacks, activities and education when possible. During an interview, on 4/4/25 at 9:45 a.m., the DON indicated the staff were encouraged to use foot pedals when transporting a resident. The review of the facility's current policy on Fall Management Program included, but was not limited to, "...Trilogy health Services (THS) strives to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. THS recognizes even the most vigilant efforts may not prevent all falls and injuries. In those cases, intensive efforts will be directed toward minimizing or preventing injury..." 3.1-45(a)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and interview, the facility failed to ensure a resident with a history of Urinary Tract Infection (UTIs) was provided proper management of the urinary catheter drainage system by maintaining the drainage system off the floor for 1 of 4 residents reviewed for bowel and bladder. (Resident 51) Findings include: During an observation, on 4/3/25 between 11:45 a.m. and 12:22 p.m., Resident 51 was sitting in the Legacy Lane Dining Room in her wheelchair. Resident 51's urinary catheter bag was two thirds	F 0690	***F690: Bowel/Bladder Incontinence, Catheter, UTI*** ***What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** Identified resident #51 as having the potential to be affected by the cited deficiency. No signs/symptoms of any adverse findings of alleged deficient	04/18/2025

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	full of urine which was sitting on the floor. The tubing was also lying on the floor with yellow urine and sediment in the tubing. The resident's feet were stepping on the tubing as the resident moved the wheelchair forward and backward. The resident began rolling away from the table with the catheter bag and tubing dragging the floor. The catheter bag could be heard scrapping the floor as it was dragging on the floor. There were 8 to 10 staff members in the dining room during the observation. During an observation, on 4/4/25 at 8:15 a.m., Resident 51 was sitting in the Legacy Lane Dining Room in her wheelchair. The urinary catheter bag was a quarter full of urine and was sitting on the floor. The tubing was also lying on the floor with yellow urine and sediment in the tubing. The resident had non-skid socks on their feet, which were resting on the tubing. Four staff were present in the dining room during the observation. The record for Resident 51 was reviewed on 4/3/25 at 3:25 p.m. The resident's diagnoses included, but were not limited to, urinary tract infection (UTI), stage 3 chronic kidney disease, dementia, and retention of urine. The Urinalysis (UA) Results, dated 7/28/24, indicated the urine had a 7.5 urine potential of hydrogen (UPH), trace leukocytes, 10-50 cells per high power field (hpf) and occasional bacteria and squamous epithelial cells (SQEPI). The culture result indicated 10,000 to 50,000 Colony Forming Units (CFU) per mL of gram-positive cocci and enterococcus faecalis. The Admission Minimum Data Set (MDS) assessment, dated 8/2/24, indicated the resident was severely cognitively impaired. The resident		practice. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** *All other residents who have a foley catheter in place has the potential to be affected by the alleged deficient practice. ***What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur:** *CS provided education to DHS/ADHS regarding proper placement of foley catheter on 04/07/2025. *DHS/ADHS provided education to licensed nurses and certified caregivers regarding proper placement of foley catheter and Surgilast placement for all resident's with foley catheters 04/07/2025 to 04/11/2025. *100% audit of resident's with foley catheters to ensure correct placement at the time of audit which was completed on 04/07/2025. *Surgilast (tubular elastic bandage) ordered to be placed on foley catheter tubing to provide barrier. Facility received and implemented placement of	

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	required intermittent catheterization. The nurse's note, dated 9/9/24 at 5:05 a.m., indicated the resident pulled the urinary catheter out and it was on the floor mat beside the bed, with the 30 milliliter (mL) balloon intact. The resident had gotten down on the floor mat and crawled. A new 16 French urinary catheter with a 30 mL balloon was inserted by sterile technique with good urine return to the bedside drain. The UA results, dated 9/9/24, indicated 2 plus urobilinogen (UBLO), 2 plus leukocytes, 10 to 50 #/HPF, 1 plus bacteria and occasional SQEPI. The culture results indicated 50,000 to 100,000 CFU/mL gram negative bacilli and Enterobacter cloacae. The Interdisciplinary Team (IDT) note, dated 9/12/24 at 8:58 a.m., indicated the physician reviewed the urine culture and gave new orders for 250 milligrams (mg) of Tetracycline three times daily for ten days. The care plan, dated 10/7/24 and revised 1/22/25, indicated the resident had a suprapubic catheter or indwelling catheter for a diagnosis of obstructive uropathy. The interventions, dated 10/7/24, included, but were not limited to, maintain a closed system with the urinary bag below the resident's bladder and keep covered, keep the leg strap in place to prevent the resident's catheter from being pulling out, observe for any signs of complication such as a urinary tract infection, urethral trauma, strictures, bladder calculi or silent hydronephrosis and notify the physician, observe the tubing and avoid any obstructions, record the resident's urinary output, provide assistance with catheter care, and change the indwelling catheter per the physician's orders.		Surgilast on 04/16/2025. ***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 practice?** **DHS/ADHS or designee to visually verify proper catheter and Surgilast placement for three residents as available weekly x4 weeks, then every other week x2 months, then monthly x3 months. * As a quality measure, DHS/ADHS or designee, will review any findings and corrective action at least monthly and ongoing until campus achieves one hundred percent compliance in the campus QAPI meetings. The plan will be reviewed and update as warranted. Compliance Date: 04/18/2025	

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	The UA results, dated 10/16/24, indicated the urine clarity was cloudy with a trace of blood in the urine, 3 plus leukocytes, 50-100 #/HPF white blood cells, 2 plus bacteria, and few hyaline casts (HYST). The culture result indicated greater than 100,000 CFU/mL gram negative bacilli and Escherichia coli. The IDT note, dated 10/21/24 at 2:40 p.m., indicated the urine culture was reviewed and reported to the nurse practitioner (NP). A new order for 100 mg of Doxycycline twice daily for 7 days was received. The nurse's note, dated 10/31/24 at 6:02 a.m., indicated a 16 French urinary catheter was placed with 30 mL of water with no problems. The resident had no complaints of pain or discomfort through the procedure. Staff were to continue to monitor the resident. The nurse's note, dated 11/21/24 at 6:49 a.m., indicated the resident had been up all night and had pulled the urinary catheter out with the bulb intact. The resident was very restless and did not comprehend to not pull her catheter out, when staff encouraged her not to do so. A 16 French 30 mL urinary catheter was reinserted without difficulty per the physician's order. The nurse's note, dated 11/21/24 at 1:41 p.m., indicated the resident had agitation toward staff and increased confusion during the night. The physician was notified and a new order for a urinalysis was completed. Family was notified and indicated cephalexin had worked best in the past. The physician was notified of this but indicated to wait for the urinalysis results. The UA results, dated 11/21/24, indicated the			

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	urine had 7.5 UPH, trace UBLP, 2 plus leukocytes, 10 to 50 #/HPF WBC, and 3 plus bacteria. The culture results indicated greater than 100,000 CFU/mL of gram-negative bacilli and Escherichia coli and 10,000 to 50,000 CFU/mL of gram-positive enterococcus faecalis. The IDT note, dated 11/25/24 at 10:17 a.m., indicated the resident had a UTI and began an antibiotic (ABT) regime of Levaquin. The resident had confusion related to the UTI. Staff were to closely monitor the resident. The nurse's note, dated 11/25/24 at 12:03 p.m., indicated the Levaquin was discontinued at this time. A new order for 250 mg of Tetracycline twice daily for 10 days was received for the diagnoses of a UTI. The nurse's note, dated 12/3/24 at 9:26 p.m., indicated the resident continued to receive an ABT related to the UTI with zero adverse effects. The resident was afebrile and voiced no complaints of pain or discomfort with voiding. The indwelling catheter was anchored per the physician's order. Fluids were encouraged and tolerated well by the resident. The nurse's note, dated 12/14/24 at 2:16 a.m., indicated the resident had pulled on the urinary catheter tubing multiple times. Redirection was provided and was somewhat effective. A Certified Nurse Aide (CNA) assisted the resident to bed at this time and provided incontinence and catheter care. The nurse's note, dated 12/24/24 at 12:02 a.m., indicated the resident had pulled the urinary catheter out. The resident was agitated and refused the new catheter placement. The nurse			

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	and two CNAs attempted to calm and educate the resident on the purpose of the urinary catheter. The resident was yelling at staff and demanded to speak with family. The family called the resident, and the resident calmed down. The resident then agreed to the urinary catheter placement. A new 16 French catheter with a 30 mL balloon was placed. The Quarterly MDS assessment, dated 1/15/25, indicated the resident was severely cognitively impaired. The resident required a urinary catheter. The nurse's note, dated 3/22/25 at 7:14 a.m., indicated the resident's urinary catheter was patent. The resident's urine was dark in color with sediment. The physician was notified and a new order to send the urine specimen out for urinalysis was completed. The urine specimen collected was placed in the laboratory refrigerator for pick up, and the lab work was ordered. The UA results, dated 3/22/25, indicated the urine had cloudy clarity urine, 2 plus UBLO, 1 plus protein, positive urinary tract infection (UNIT), 2 plus leukocytes, 10 to 50 #/HPF WBC, 3 plus bacteria, a moderate amount of Baker's Yeast, Immunoglobulin E, Serum (BYST). The culture result indicated greater than 100,000 CFU/mL of mixed growth. The nurse's note, dated 3/24/25 at 4:15 a.m., indicated the resident's urinary catheter was intact and patent and was draining yellow urine with sediment. The urine was sent to the laboratory. The nurse was awaiting the results. The nurse's note, dated 3/24/25 at 6:55 p.m., indicated the urinalysis was complete and indicated a culture would be completed at this			

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	time. The physician was notified with no new orders. The nurse was awaiting the final culture and sensitivity. The nurse's note, dated 3/25/25 at 2:14 p.m., indicated the urine culture was back with no growth. The physician was notified, and no new orders were indicated. The nurse's note, dated 3/28/25 at 1:29 p.m., indicated the resident's urinary catheter was intact and patent. The resident had a normal urinary output. No complaints of pain or discomfort were observed at this time. Staff would continue to monitor for further changes. During an interview, on 4/4/15 at 8:29 a.m., the Legacy Lane Supervisor indicated Resident 51's urinary catheter bag should not be on the floor. The resident played with her urinary catheter bag quite a bit. The resident would feel the tubing rubbing on their leg and pull on it. During an interview, on 4/4/25 at 8:55 a.m., CNA 9 indicated that she didn't know Resident 51's catheter was on the floor. It was on the bed attached to the side rail, when the CNA transferred the resident from the bed to the wheelchair. The CNA attached the urinary catheter bag onto the underside of the wheelchair, where it wasn't visible, as she was taught to do 26 years ago. The CNA then brought the resident into the dining room. Upon the CNA observing where the Legacy Lane Supervisor had moved the urinary catheter bag, onto the back underside of the wheelchair, the CNA indicated the urinary catheter bag was not where she had placed it. The urinary catheter bag shouldn't have touched the floor, for sanitary reasons or it could make the resident sick.			

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	The Patient with a Foley Catheter policy, revised 8/5/22, included, but was not limited to, " ... Patient Teaching ... 2. Do not let catheter tubing or drainage bag touch floors. (Avoids infection) ..." 3.1-41(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review and interview, the facility failed to ensure a resident's weight was verified for 1 of 5 residents reviewed for nutrition and hydration. (Resident 35) Findings include: The record for Resident 35 was reviewed on 4/3/25 at 11:23 a.m. The resident's diagnoses included, but were not limited to, pleural effusion, acute respiratory syncytial virus, hypertensive heart disease with heart failure, endocarditis, dementia, cardiomegaly, and edema. The physician's orders, dated 12/30/24, indicated the resident was prescribed furosemide 20 milligrams (mg) once a day for bilateral lower extremity edema. The Quarterly Minimal Data Set (MDS) assessment, dated 3/3/25, indicated the resident was moderately cognitively intact. The care plan, dated 3/31/25, indicated the resident had experienced significant weight loss. The interventions included, but were not limited to, offer the resident encouragement and assistance with eating, weights as ordered by the physician, and provide diet, supplements,	F 0692	***F692: Nutrition/Hydration Status Maintenance*** ***What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice:** Identified resident #35 as having the potential to be affected by the cited deficiency. Resident remains at campus with stable weight and no adverse reactions to weight change. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** * All other residents noted with significant weight change has the potential to be affected by the alleged deficient practice. All resident's identified as having a significant weight change were verified for accuracy.	04/18/2025

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	medications, adaptive equipment, and snacks as ordered. The nurse's note, dated 1/17/25 at 3:29 p.m., indicated the resident was added to Clinically at Risk (CAR) list related to a significant weight change. The resident's current weight was observed to be 189.4 pounds. The resident preferred to sit up in her chair throughout the day and had a history of bilateral lower extremity edema. The resident's weight fluctuations were expected as dependent edema appears and resolves. The nurse's note, dated 2/7/25 at 3:48 a.m., indicated the resident was reviewed in CAR related to a significant weight change. The resident's current weight was observed to be 195.2 pounds. The resident appeared to have adequate nutritional intake. Will continue to monitor weights as ordered and as the residents allowed. The nurse's note, dated 3/5/25 at 11:17 a.m., indicated while the resident was getting a shower the resident's right leg and foot were swollen and red. After getting out of the shower her vitals were taken. The resident's oxygen saturation (02) was at 89 percent. The resident complained of her heart fluttering. While sitting in her chair she was short of breath. After getting the resident in her recliner, an assessment was completed. The resident's 02 levels would fluctuate at rest and when she spoke. The resident's 02 ranged between 86 to 89 percent. The tips of fingers were tinted blue. The resident was given 02 at 2 liters (L) of oxygen. The resident verbalized pain when she lifted her right leg. The Nurse Practitioner (NP) was contacted, and the resident was sent to the hospital. He said the hospital was fine to take her. The NP indicated it could be exacerbated		***What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur:** *CS provided education to DHS/ADHS regarding nutrition/hydration and verifying accuracy of weights on 04/07/2025. *DHS/ADHS provided education to licensed nurses and certified caregivers regarding nutrition/hydration and verifying accuracy of weights 04/07/2025 to 04/11/2025. *100% audit completed on 04/11/2025 for all residents noted with a significant weight change for verification of accuracy of weight. ***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 practice?** **DHS/ADHS or designee to review facility activity report including vital signs out of range with emphasis on weights Monday through Friday during clinical care meeting and obtain reweight as applicable to determine accuracy	

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	congestive heart failure but needed to rule out a deep vein thrombosis. Review of the resident's weights indicated the following: - On 3/5/25 the resident's weight was 194.5 pounds. - On 3/12/25 the resident's weight was 189.7 pounds. The readmission weight after a hospital stay. - On 3/16/25 the resident's weight was 188.7 pounds. - On 3/23/25 the resident's weight was 145.4 pounds. - On 3/30/25 the resident's weight was 145.4 pounds The record lacked documentation indicating the facility verified the resident's weight loss when changes occurred. During an interview, on 4/3/25 at 9:36 a.m., the Director of Nursing (DON) indicated she did not know why the resident had lost a significant amount of weight. She indicated she knew the resident had diuresis (increased excretion of urine) at the hospital. She thought maybe the resident was weighted in her wheelchair and the nurse did not subtract the weight of the wheelchair. During an interview, on 4/3/25 at 10:00 a.m., the Registered Dietician (RD) indicated the resident's weight loss was being investigated at this time. The resident had a big shift in weight, and she was not sure why. She was working with the DON		of weight. * As a quality measure, DHS/ADHS or designee, will review any findings and corrective action at least monthly and ongoing until campus achieves one hundred percent compliance in the campus QAPI meetings. The plan will be reviewed and update as warranted. Compliance Date: 04/18/2025	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to try and figure out why. She indicated the resident had diuresis at the hospital, but the weight loss was still unusual. The resident had her diuretic dose increased and the resident was on a low sodium diet. The RD was monitoring the resident's weight weekly. The RD discussed weight loss with the DON today and they were going to recheck the resident's weight and the weight of the wheelchair. The RD indicated she was going to meet with the DON on Monday and discuss the residents weight loss. During an interview, on 4/4/25 at 8:30 a.m., RN 4 indicated the unit used a weight chair to weigh the residents. Staff would transfer the residents from the wheelchair to the weight chair. The weight scale did not require the residents to be weighed in their wheelchair. When there was a discrepancy in the resident's weight staff would reweigh the resident and inform the DON, physician and the family. During an interview, on 4/4/25 at 9:45 a.m., the DON indicated the resident should have been reweighed to make sure the weight was accurate and verify the weight. The physician should have been notified. The review of the facility's current policy on Guidelines for Hydration Management dated 12/17/24, included, but was not limited to, "...To identify residents at risk from dehydration and implement individualized interventions which promote sufficient fluid intake to maintain proper hydration... 2. Review assesment and analyze data. Criteria respresenting risk factors may include, but are not limited to: b. Diuretic medications..." 3.1-46(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	04/04/2025

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