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	155455	A. BUILDING 00 B. WING	12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESLEYAN HEALTH CARE CENTER	729 WEST 35TH ST MARION, IN 46953

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaints IN00422812 and IN00421594. This visit included a State Residential Licensure Survey. Complaint IN00422812 - No deficiencies related to the allegations are cited. Complaint IN00421594 - No deficiencies related to the allegations are cited. Survey dates: November 27, 28, 29, and 30 and December 1 and 4, 2023. Facility number: 000557 Provider number: 155455 AIM number: 100291240 Census Bed Type: SNF: 2 SNF/NF: 94 Residential: 6 Total: 102 Census Payor Type: Medicare: 4 Medicaid: 58 Other: 34 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 11, 2023.	F 0000	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully request a desk review for compliance.	
F 0680 SS=E	483.24(c)(2)(i)(ii)(A)-(D) Qualifications of Activity Professional			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debra Smith	RN DCS	12/15/2023

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Bldg. 00	§483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. Based on interview and record review, the facility failed to ensure the activity director completed the required education to meet the qualifications for an activity director. Finding includes: Employee records were reviewed on 11/29/23 at 4:00 p.m. The records lacked documentation of the required training for the Activity Director. During an interview on 11/30/23 at 10:19 a.m., the Administrator indicated the Activity Director began her position on 9/28/23. She was not currently certified. During an interview on 11/30/23 at 10:25 a.m., the Activity Director indicated she had registered for the Activity Director course on 11/30/23. Review of a current job description for the	F 0680	No residents were identified as affected by the alleged deficient practice. Interim Activities Director hired that has already completed Activity Director Course. Residents that reside in the facility have the potential to be affected by the alleged deficient practice. Future hires for Activity Director will have completed the course and have the certification prior to hire. The Administrator will review the qualifications of any future hires for Activity Director. Proof of Education will be maintained in the employee file. Activity Director files and	12/22/2023

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	Activity Director, revision date 5/1/09, and provided by the Nurse Consultant on 12/4/23 at 3:30 p.m., indicated the following: "...Desired qualifications include: Being a graduate of a state approved Activity Director course preferred, but not required ...."		certification will be reviewed prior to hire or advancement to Activity Director to ensure that the qualifications have been met. QAPI will follow for a minimum of 6 months.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to implement care plan interventions to reduce the risk of falls for 1 of 3 residents reviewed for accidents. (Resident 95) Findings include: During an observation, on 11/28/23 at 11:17, Resident 95 was in his room, seated in his wheel chair. A record review performed on 11/29/23 at 1:18 p.m. indicated the following: Review of Resident 95's clinical record was completed on 11/29/23 at 1:18 p.m. Diagnoses included vascular dementia without behavioral disturbance, transient ischemic attack (TIA), and type 2 diabetes mellitus with diabetic polyneuropathy.	F 0689	Resident # 95 care plan has been reviewed and updated to reflect fall risk and appropriate interventions. Residents that have had fall and/or are at high risk based on fall risk assessment have the potential to be affected by the alleged deficient practice. Fall risk scores have been reviewed to identify residents at high risk for falls. Care plans have been reviewed and updated as indicated with fall interventions to include current interventions. Education has been completed on locating the fall interventions in the Medical Record and on the Kardex and following fall care plan interventions. Care plans of residents residing in the facility	12/22/2023

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	The resident's care plan, initiated on 9/20/23, indicated he was at risk for falls related to impaired balance, moderate cognitive deficits, and use of psychotropic medications. A progress note, dated 10/14/23 at 2:45 p.m., indicated the resident tried to transfer to the restroom without his walker. The immediate intervention was to remind the resident to use his walker when up, use his call light, and to wait for help to walk to the bathroom. A sign was posted in the room to remind the resident to call for help. An interdisciplinary team (IDT) note, dated 10/16/23 at 2:07 p.m., indicated a new intervention to make sure non-slip socks were on the resident at all times. A progress note, dated 11/21/23 at 12:31 p.m., indicated the IDT determined the fall to be related to the resident's loss of balance. CNA 3 was reminded she should have another staff member with her when transferring the resident. An IDT progress note, dated 11/22/23 at 11:09 a.m., indicated the resident was to have two staff members to assist with his transfers. A progress note, dated 11/23/23 at 10:06 a.m., indicated the resident was assisted to the restroom by one staff member, CNA 3. During the transfer, he lost his balance and fell. A progress note, dated 11/30/23 at 8:19 p.m., indicated the resident was found lying on the floor next to his bed. The immediate intervention was to replace the resident's regular socks with non-skid socks (which was previously developed on 10/16/23).		have been reviewed and updated as indicated. Fall risk scores for residents residing in the facility have been reviewed. Fall intervention rounds developed from care plan reviews. A rounding Audit tool will be used daily X 4 weeks, then 3X week for 8 weeks, and then quarterly for a minimum of 6 months or until substantial compliance has been achieved as defined by QAPI. Non-compliance will result in re-education and progressive discipline will be completed.	

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	During an interview with CNA 3, on 12/4/23 at 9:30 a.m., she indicated the fall on 11/23/23 happened when the resident had initially refused to go to the restroom when she offered assistance. His daughter was present at the time and encouraged him to go ahead and let the CNA take him to the restroom. It was during the transfer to the restroom that the resident fell. During an interview with the Director of Nursing (DON), on 12/4/23 at 1:40 p.m., she indicated the resident had dementia and was very impulsive. He tried to get up by himself repeatedly and, as a result, she had implemented many interventions. The resident had been educated about the need to ask for assistance when transferring. He could be educated, but did not remember the education later. The staff was updated on interventions using a Kardex system. The Kardex system was available in a hard copy and electronically. The unit manager also updated staff about changes to the care plan. The CNA had been updated on the intervention to provide two staff members present when assisting the resident. CNA 3 had found the resident already in the restroom and was just trying to help the resident when the fall occurred. The CNA was more concerned about helping him at the moment than trying to find another staff to assist her with the transfer. Regarding the lack of non-skid socks when the resident fell on 11/30/23, he had been wearing shoes and socks. After dinner, he had taken off his shoes and put himself in bed. When he fell out of his bed, he had been wearing the regular socks. A facility document, titled "Fall Investigation and Risk Evaluation", with a revised date of 6/22, was provided by the DON. The policy indicated the following: "...It is the policy of this facility to provide an environment that is free from accident			

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	hazards over which the facility has control and provides supervision and assisted devices to prevent avoidable accidents...All residents will have a care plan developed that includes the resident's complications and risks, an attainable and measurable goal, and individualized interventions to decrease their risk of falls...." 3.1-45(a)(2)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive			

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	psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, record review, and interview, the facility failed to ensure a resident did not receive an antipsychotic without an indication of use for 1 of 5 residents reviewed for unnecessary medications (Resident 31). Findings include: During an observation, on 11/29/23 at 1:50 p.m., Resident 31 was sitting in his room. During a wound observation, on 12/1/23 at 2:03 p.m., the resident was cooperative with care. His clinical record was reviewed on 11/28/23 at 2:03 p.m. Diagnoses included major depressive disorder, recurrent, mild and anxiety disorder. Current physician orders included observe for side effects (antipsychotic, antidepressant,	F 0758	Resident #31 has been visited by Psych NP and orders were obtained to complete gradual dose reduction and discontinuation of the antipsychotic medication. Care plan and diagnosis were reviewed and updated as indicated. Residents that receive antipsychotic medications have the potential to be affected by the alleged deficient practice. An audit of current residents that receive antipsychotic medications has been completed to ensure an appropriate indication for use is in place. Education has been completed	12/22/2023

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	antianxiety, hypnotic) (3/24/22), Seroquel (antipsychotic) 50 mg tablet, give half tablet (25 mg) two times a day for depression(7/26/23), lorazepam (antianxiety) oral concentrate 2 mg/ml, give 0.25 ml for 0.5 mg every evening for anxiety (8/4/23), and Zoloft (antidepressant) 25 mg tablet, give one tablet once a day for major depressive disorder, recurrent, mild (8/17/23). A 10/24/23 significant change MDS (Minimum Data Set) assessment indicated he was cognitively intact. He had verbal behavioral symptoms directed towards others (example; threatening others, screaming at others, cursing at others). Behavior of this type had occurred one to three days during assessment period. This behavior did not put him at significant risk for illness or injury, did not significantly interfere with his care or his participation in activities or social interactions. He had rejection of care for one to three days of the assessment period. There had not been a change in his behavior or other symptoms since the prior MDS assessment. He had received an antipsychotic, antianxiety, and antidepressant. A current care plan, with a revision date of 11/9/23, indicated he was at risk for side effects related to the use of antidepressants, antianxiety and antipsychotics. His goal was he would not have adverse effects from the use of his medication for his mental health and psychological well being. Interventions included he would report and staff would observe for adverse side effects related to the need for an antidepressant, and for adverse side effects related to the need for an antipsychotic to treat his mental health, his psychotropic medications would be reviewed quarterly by a pharmacist and the interdisciplinary team to ensure the need for		with staff on 12/13/2023 on the appropriate indications for the use of antipsychotic medication. An audit of residents receiving antipsychotic medications has been completed and care plans and diagnosis have been updated as indicated. Residents that admit with or receive new orders for antipsychotic medications will be reviewed to ensure that an appropriate indication for use is in the medical record. Current residents will continue to be reviewed at least quarterly for gradual dose reductions. Antipsychotic medications, diagnosis and gradual dose reductions will be followed in QAPI for a minimum of 6 months or until QAPI determines substantial compliance.	

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	continued use and the appropriateness for a gradual dose reduction, he would be educated of the risks of refusing care, the benefits of care, and his rights to choose would be respected, if he started yelling and cursing, set boundaries, tell him staff would return in a certain number of minutes, staff would return within the given timeframe and report behaviors to the nurse or social services, redirected with quick intervention when behavior began as to avoid escalation. A current care plan, with a revised date of 11/13/23, indicated he utilized antianxiety medication for a diagnosis of anxiety. His symptoms included, rushing others, restlessness, worry, nervousness, and repetitive phrases. The goal indicated he would have less than two episodes a week of anxiousness and anxiety would be calmed within five minutes of staff interventions. Interventions included staff answered his questions and met his immediate care needs, invited him to food related and special event activities related to his preference, listened to his feelings and reframed his thoughts to positive such as talking about what I used to do, and provided reassurance. A current care plan, with a revised date of 11/9/23, indicated he utilized an antipsychotic medication and an antidepressant medication for the diagnosis of depression and major depressive disorder. It was displayed in frustration/anger, resisting care, threats, unrealistic expectations of care, and repetitive movements or phrases. The goal indicated he would have less than two episodes a week of mood distress and mood distress would be calmed within five minutes of staff intervention. Interventions included he would be allowed to express his feelings, he was educated on signs, symptoms, care, and treatment			

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	options, encouraged to actively participate in his activities of daily living, he received his medications as ordered, he reported and staff observed for changes in his depression symptoms. A Behavior Sheet note, dated 10/15/23 at 5:31 a.m., indicated Resident 31 had been verbally aggressive and threatened staff he would have them fired. A staff member explained to him that everyone was doing their best. He continued to yell and curse. A Behavior Sheet note, dated 10/15/23 at 4:34 p.m., indicated he had yelled out of his door for help and his call light was on. A staff member explained to him that they had quite a few residents and only so many staff members, and told him as soon as they were done they would make sure they came to him. He indicated his light had been on since 1:30 p.m. and staff member explained they didn't arrive until 2:00 p.m. A Behavior Sheet note, dated 12/1/23 at 8:09 a.m., indicated he had repetitive verbalizations and yelling/screaming that had been moderate in intensity. Staff approached him in a calm manner and validated his feelings, which improved his behavior. A review of behaviors in the look-back report of his clinical record indicated on 10/22/23 at 1:59 p.m., he had behaviors of yelling/screaming, abusive language, and threatening behavior. Interventions had been refused. A Geri-Psych Note, dated 10/26/23 at 1:00 a.m., indicated his PHQ-9 (Patient Health Questionnaire) for depression on 10/26/23 was zero out of 27, with no self-reported depressive			

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	symptoms. During the session, he presented as neutral with flat affect. Supportive therapy, cognitive stimulation, empathetic listening, and emotional support to help explore and promote adaptive management of negative affect and mood were provided. Psychological services were recommended to monitor cognitive changes and related behavioral issues. A Geri-Psych Note, dated 11/9/23 at 12:00 a.m., indicated he had been referred for psychological evaluation and treatment to establish care for ongoing monitoring and management of mood and behaviors. He had a history of depression and anxiety. During the session, he presented as depressed with flat affect. Supportive therapy, cognitive stimulation, empathetic listening, and emotional support to help explore and promote adaptive management of negative affect and mood were provided. Psychological services were recommended to monitor cognitive changes and related behavioral issues. The long term goal for his depression was to reduce the frequency, intensity, and degree of impairments related to depression symptoms to improve his daily functioning. An Interdisciplinary Team note, dated 11/9/23 at 9:39 a.m., indicated the team had reviewed and adjusted his behavioral, mood, and cognitive care plans to meet his current needs. He had been noted to be content without concerns. A Behavior Management Team Review, dated 11/24/23 at 9:17 a.m., indicated he had been placed back on behavior management for increased demanding/verbal aggression behavior. In the past 30 days, he had experienced three occurrences and two alerts. Medical			

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	considerations for behaviors included stroke, dementia. Participating and contributing factors lacked patterns. Medications were reviewed and included Zoloft 25 mg daily, Seroquel 25 mg twice a day, and lorazepam 0.5 mg every evening. A Geri-Psych Note, dated 11/28/23 at 12:00 a.m., indicated he was seen for a follow up to assess his current psychiatric status and review psychotropic medications. The SSD had reported he was at his baseline. Staff had indicated he continued to refuse care at times and had verbal aggression towards staff when approached. He continued to receive Seroquel and Zoloft for depression as well as lorazepam for anxiety. He was observed in his room, lying in bed with his eyes closed. He appeared to be calm and comfortable. He had three behaviors in the past month and two alerts, per the SSD. Staff were to observe for significant changes in mood/behaviors including sadness, anhedonia (lack of interest, enjoyment or pleasure from life's experiences), tearfulness, hopelessness, isolating in room, feelings of guilt, and decreased appetite. A Geri-Psych Note, dated 11/30/23 at 12:00 a.m., indicated he had been referred for psychological evaluation and treatment to establish care for ongoing monitoring and management of mood and behaviors. He had a history of depression and anxiety. The session summary included SSD (Social Service Director) had indicated he had some irritability and agitation recently. During the session, he presented as depressed with flat affect, he was sleepy and in bed. His affect, tone, and demeanor indicated depression. Supportive therapy, cognitive stimulation, empathetic listening, and emotional support to help explore and promote adaptive management of negative affect and mood were provided. Psychological			

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	services were recommended to monitor cognitive changes and related behavioral issues. A Social Service Behavior note, dated 12/1/23 at 12:11 p.m., indicated he had been noted for yelling and cussing at staff, called them names, and demanded a lift chair from the facility. Interventions included staff redirected him and validated his feelings. He was transferred into his bed where he was more comfortable and was able to calm down. During an interview, on 12/4/23 at 10:50 a.m., LPN 5 indicated Resident 31 occasionally had behaviors of hollering out if he thought care had not been provided timely and redirection was effective. During an interview, on 12/4/23 at 10:56 a.m., CNA 12 indicated he yelled and screamed if his light didn't get answered right away. The interventions used included leave and re-approach and try another care-giver During an interview, on 12/4/23 at 11:06 a.m., QMA 7 indicated he he yelled out and resisted care at times. During an interview, on 12/4/23 at 11:07 a.m., the ASSD (Assistant Social Service Director) indicated the resident believed his care should be a priority above others and was non-complaint with care. He had different responses to different staff, if staff explained they needed to tend to another resident and would be right back that was effective at times. During an interview, on 12/4/23 at 11:13 a.m., the SSD indicated the resident was monitored for verbal aggression and demanding behaviors. He			

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	was not a patient person, interventions included to reassure him, give him time frames, divert his attention, and engage him in conversation. He was seen by a geri-psych service, a counselor came twice a month and the nurse practitioner came one a month. For the monthly behavior meetings they reviewed behavior sheets and behavior alerts, they summarized what had happened during the month to see if new interventions were needed. He received an antianxiety medication for anxiety, an antidepressant for depression, and an antipsychotic for depression as an adjunct to the antidepressant. His life history included not being a patient person and had a bad temper. Review of a current facility policy, titled "PSYCHOACTIVE MEDICATIONS/GRADUAL DOSE REDUCTION (GDR)/UNNECESSARY MEDICATIONS POLICY," with a revised date of 4/23 and provided by the DON on 12/4/23 at 11:49 a.m., indicated the following: "...Policy: It is the policy of this facility that a resident will receive medications and psychoactive medications only when it is necessary to improve the resident's overall psychosocial health status...14. UNNECESSARY DRUGS - Every resident's drug regimen is to be free from unnecessary drugs. An unnecessary drug is any drug when used:...Without adequate indications for its use; * Medication is prescribed for a diagnosed condition and not being used for convenience or discipline. * Medication is clinically indicated to manage a resident's symptoms or condition where other causes have been ruled out. * Signs, symptoms, or related causes are persistent or clinically significant enough (e.g., causing functional decline) to warrant the initiation or continuation of medication therapy...."			

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	Review of the FDA (Food and Drug Administration) website, https://www.accessdata.fda.gov/drugsatfda_docs /label/2013/020639s061lbl.pdf, indicated the following indications and uses for Seroquel: schizophrenia, bipolar disorder, and special considerations in treating pediatric schizophrenia and bipolar I disorder. 3.1-48(a)(4)			
F 0882 SS=F Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP) had sufficient time to perform IP responsibilities by requiring the full-time DON to assume the (at minimum) part-time IP role with a facility census of 96 residents. This deficient practice had the potential to affect 96 of 96 residents who resided at the facility.	F 0882	No residents were identified as affected by the alleged deficient practice. Residents that reside in the facility have the potential to be affected by the alleged deficient practice. Additional education has been	12/22/2023

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	Finding includes: During an interview, on 11/27/23 at 10:13 a.m., the DON indicated she was both the full-time DON and the infection preventionist for the facility. The facility census provided on 11/27/23 at 10:13 a.m. by the DON, indicated the facility census was 96. During an interview, on 12/4/23 at 2:55 p.m., the DON indicated she oversaw the infection prevention and control program at the facility. The unit managers turned in individual infection sheets daily as needed. She transferred those to her surveillance sheets and facility maps of infections. She gathered much of her daily information at morning meetings. She monitored infections daily. She was unable to account for times she functioned as the DON or the IP as she did not document such and was uncertain of the breakdown of times. She was the only facility staff person with the required infection control and prevention training. The facility had not offered the pneumococcal conjugate vaccine (PCV) 20 (for pneumonia) to residents who had previously received the pneumococcal conjugate vaccine (PCV) 13 (for pneumonia) or the pneumococcal polysaccharide vaccine (PPSV) 23 (for pneumonia) as recommended by the Centers for Disease Control and Prevention (CDC). According to the CDC website page "Adult Immunization Schedule," https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html#note-pneumo, accessed on 12/5/23 at 10:39 a.m., indicated for those 65 years of age or older: 1. If previously received only the PCV13 then one dose of PCV20 or one dose of PPSV23		completed with the CDC Infection Preventionist Modules with a minimum of one nurse that will perform the Infection Preventionist responsibilities. The facility will ensure that a minimum of one nurse has received additional training in Infection Control to qualify as the Infection Preventionist for the facility. The Director of Nursing will not perform the role and it will be followed by QAPI for a minimum of 6 months to ensure substantial compliance.	

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	should be given at least one year after the administration of the PCV13. 2. If previously received only the PPSV23 then one dose of pneumococcal conjugate vaccine (PCV) 15 or one dose of the PCV20 should be administered at least one year after the administration of the PPSV23. 3. If both the PCV13 and the PPSV23 were received, but no PPSV23 was received after the age of 65 years or older then one dose of PCV20 should be administered or one PPSV23 should be administered at least five years after the last vaccine dose. 4. If both PCV13 and PPSV23 were administered, and PPSV23 was received at 65 years or older, then based on shared clinical decision-making, one dose of PCV at least five years after the last pneumococcal vaccine dose should be given. A current facility job description for Infection Preventionist, revised 1/17/20, provided by the Consultant Nurse on 12/4/23 at 3:30 p.m., indicated the IP must provide the following: "...Oversight of the IPCP [infection prevention and control program], which includes ...a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors ...following accepted national standards ...assess the need for, develop, and present IPCP in-service education for individual departments, general orientation, and annual review as needed; education includes but is not limited to ...Resident immunization programs ...." The working conditions included, " ...At times needed to work beyond normal working hours such as weekends/holidays and on other shifts ...." A current facility job description for the Director of Clinical Services (also called the DON), revised			

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	on 12/5/19, provided by the Consultant Nurse on 12/4/23 at 3:30 p.m., indicated " ...The primary purpose of this position is to set resident care standards for all direct care standards for all direct care providers and provide complete supervision/management for the nursing department. This position includes planning, organizing, implementing, evaluating and directing the overall operation of Nursing Services within the guidelines of the facility policies and with strict adherence to all local, state and federal regulations ..." The working conditions included " ...At times needed to work beyond normal working hours such as weekends/holidays and on other shifts ...."			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's			

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	representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on interview and record review, facility failed to ensure residents received accurate, up-to-date information on currently available vaccinations for 3 or 5 residents reviewed for immunizations (Residents 7, 22, 82).	F 0883	Residents #7, 22, & 82 have been offered and educated on the Prevnar 20 vaccination and have received the vaccination if the consented to it. Documentation has been completed in the	12/22/2023

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	Findings include: 1. The clinical record for Resident 22 was reviewed on 11/29/23 at 1:14 p.m. Diagnoses included Parkinson's disease without dyskinesia, chronic obstructive pulmonary disease, acute and chronic respiratory failure without hypercapnia. She was hospitalized for double pneumonia in June 2023. Resident 22 had received pneumococcal polysaccharide vaccine (PPSV) 23 on 12/28/04 and pneumococcal conjugate vaccine (PCV) 13 on 10/7/15. She was not educated on the new PCV 20 vaccination, which came out on 6/8/21. CDC recommendations indicated to give one dose of PCV 20 at least 5 years after the last pneumococcal vaccine dose. 2. The clinical record for Resident 82 was reviewed on 11/28/23 at 2:16 p.m. The diagnoses included chronic obstructive pulmonary disease and type 2 diabetes. Resident 82 was educated and declined PPSV 23 on 3/23/22. He was not educated or offered the new PCV 20 vaccination. 3. The clinical record for Resident 7 was reviewed on 11/28/23 at 2:17 p.m. The diagnoses included type 2 diabetes, immunodeficiency due to conditions elsewhere, and Parkinson's disease without dyskinesia. Resident 7 was educated and declined PPSV 23 on 7/16/19. He was not educated or offered the new PCV 20 vaccination. During an interview, on 12/4/23 at 2:55 p.m., DON indicated they have not offered the PVC 20		medical record indicating if the resident refused or consented to the vaccination. Residents that are eligible per the CDC guidance have the potential to be affected by the alleged deficient practice. Residents that reside in the facility have been offered the opportunity to receive the Prevnar 20 if eligible and if indicated. An audit of the residents current pneumonia vaccination status has been completed and residents have been offered the vaccination. Education on the Prevnar 20 has been given to the residents and or the resident representative and documented. An audit of new admissions and current residents will be completed daily Monday – Friday in morning meeting to ensure that vaccinations are offered and administered when indicated for 12 weeks then followed in QAPI for a minimum of 6 months or until QAPI determines substantial compliance is achieved.	

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	vaccine to any residents who previously had the PCV 13 or PPSV 23. The facility had gone to the PCV 20 vaccinations for new residents wanting the vaccine on admission. A current facility policy, titled "RESIDENT VACCINATION POLICY," last revised on 6/2023 and provided by the DON on 11/27/23 at 10:13 a.m., indicated the following: "...Policy All residents will be offered recommended vaccinations annually at minimum (Influenza, Pneumococcal, COVID) per CDC recommendations to encourage and promote benefits to protect against these illnesses to assist in reducing this populations significant risks...Policy Implementation...3. Pneumococcal vaccines may be offered and received at any time deemed necessary. A review of the resident's vaccine history on currently recommended pneumococcal vaccines will be done and if deficient, CDC recommended vaccines will be offered...." 3.1-13(a)			
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 Complaints IN00422812 and IN00421594. Complaint IN00422812 - No deficiencies related to the allegations are cited. Complaint IN00421594 - No deficiencies related to the allegations are cited. Survey dates: November 27, 28, 29, and 30, and	R 0000	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of	

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	December 1 and 4, 2023. Facility number: 000557 Residential Census: 6 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed December 11, 2023.		federal and state law. The facility respectfully request a desk review for compliance.	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, interview, and record review, the facility failed to ensure the sanitary condition of the laundry equipment utilized by the residents for 1 of 1 laundry areas observed. Finding includes: During an interview on 11/28/23 at 9:56 a.m., Resident 21 indicated he laundered his personal items in the washer located in the kitchen/activity lounge area. At the same time, a smear of a dried, brown substance was observed on the outer rim of a washer when the lid was lifted. The washer was an apartment style washer/dryer combination located in the kitchen/activity lounge area of the facility. During an observation, on 11/29/23 at 3:02 p.m., the same brown, dried substance remained on the outer rim of the washer in the kitchen/activity lounge area. Slightly warm personal items were laying in the attached dryer. At the time of the observation, Nurse 51 indicated she was uncertain	R 0144	No residents were identified to be affected by the alleged deficient practice. Residents that use the kitchen area and washing machine have the potential to be affected by the alleged deficient practice. The kitchen area and the laundry area were cleaned at the time directly after the washing machine was noted to be dirty. The common areas in the Assisted Living area will be cleaned daily. A checklist has been developed to ensure areas are cleaned daily in the kitchen and laundry areas. The checklist will be completed by the housekeeper and turned into housekeeping supervisor daily.	12/22/2023

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	what the substance was. She attempted to clean the area with a damp paper towel by rubbing the area vigorously. A small portion of the smear flaked off while the bulk of the area remained firmly adhered to the washer outer rim. She thought housekeeping generally cleaned the kitchen/activity lounge area daily. During an interview, on 12/4/23 at 2:30 p.m., the Housekeeping Supervisor indicated the lounge area including the washer/dryer should be cleaned daily by housekeeping. A current facility policy, revised on 6/2019, titled "Housekeeping Services," provided by the Nurse Consultant, indicated the following: " ...Policy: It is the policy of the facility to maintain a clean, odor free, comfortable and orderly environment in all health care and public areas, which meet the sanitation needs of the facility and residents right for a safe, clean, comfortable homelike environment ...Guidelines: ...2. The department shall routinely clean the environment of care, using accepted practices, to keep the facility free from offensive odors, the accumulation of dust, rubbish, dirt, and hazards ...."		The housekeeping supervisor/designee will complete rounds 5 times weekly for 12 weeks upon receiving the checklist to ensure areas have been cleaned and co-sign the checklist that indicates the area has been completed. QAPI will follow for a minimum of 6 months or until substantial compliance has been achieved as defined by QAPI.	