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	155628	A. BUILDING 00 B. WING	08/09/2022

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CREEKSIDE HEALTH AND REHABILITATION CENTER	3114 EAST 46TH STREET INDIANAPOLIS, IN 46205

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00386617. Complaint IN00386617- Substantiated. Federal/State deficiencies related to the allegations are cited at F0680. Survey dates: August 2,3,4,5,8, and 9, 2022 Facility number: 009569 Provider number: 155628 AIM number: 200139920 Census Bed Type: SNF/NF: 103 Total: 103 Census Payor Type: Medicare: 7 Medicaid: 85 Other: 11 Total: 103 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 18, 2022	F 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment.** The facility is requesting a desk review for compliance.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a resident was	F 0554	The facility will ensure this requirement is met through the	09/07/2022

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

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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	determined clinically appropriate by the Interdisciplinary team (IDT) to self-administer medications for 2 of 2 residents observed with medications left at bedside during random observations. (Residents 308 and 73) Findings include: 1. During an interview with Resident 308, a random observation was made on 8/3/22 at 9:29 a.m., of Resident 308's bedside table. On the bedside table was a plastic medication cup which contained 10 unidentified pills. Resident 308 indicated, he had been in the bathroom when the nurse came in to administer his morning medications so the nurse left the medications for him to take when he was out of the bathroom. An interview with Licensed Practical Nurse (LPN) 45 was conducted on 8/3/22 at 9:52 a.m. LPN 45 indicated, when she had gone into Resident 308's room with his medications, he was in the bathroom and so she left the medication cup with the pills on his bedside table for him to take when he was done in the bathroom. LPN 45 stated, she should not have left them in the room and that "it was a lapse in judgement". Resident 308's clinical record was reviewed on 8/3/22 and did not contain a completed self-administration of medication assessment. 2. During an interview with Resident 73, a random observation was made on 8/03/22 at 10:13 a.m. of Resident 73's bedside table. On her bedside table, was a plastic medication cup which contained 2 unidentified tablets. The interview with Resident 73 continued when LPN 4 came into the room, grabbed the medication cup with the tablets, and stated to Resident 73 that when she was ready to		following corrective measures: 1. No harm incurred to resident # 308 and resident 73. LPN # 4 and LPN # 45 immediately re educated on the medication administration policy. 2. All other resident have the potential to be affected. See below for corrective measures moving forward. 3. Licensed nurses and QMA's educated on the medication administration policy. A performance improvement tool has been initiated. The DON/Designee will complete a random medication pass audit for 8 residents per week, on varying days and shifts, for 4 weeks until 100% compliance is achieved ,then 4 residents per month for 6 months until 100% compliance is maintained. 4. The findings of these reviews will be presented to the QAPI committee during the facility's monthly meetings and the plan of action adjusted accordingly	

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	eat breakfast she will return with the medications in the cup because she can't leave them there. LPN 4 referred to the medications in the medication cup as her "phosphate binders". Resident 73's clinical record was reviewed on 8/3/22 and did not contain a completed self-administration of medication assessment. A Medication Administration policy was received from ED (Executive Director) on 8/8/22 at 2:51 p.m. The policy indicated, "x. Licensed nurse/authorized personnel MUST stay with resident to ensure medication(s) are completely ingested..." 3.1-11			
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or			

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	complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific			

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	allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.			
	Based on observation, interview, and record	F 0585	The facility will ensure this requirement is met through the	09/07/2022

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	review, the facility failed to thoughoughly investigate grievances of damaged property and of staff using inappropriate language when addressing a resident, inform a resident of their right to obtain a copy of the results of the grievance investigation, and to ensure prompt resolution of a resident's grievance regarding his missing wheel chair for 2 of 3 residents reviewed for personal property. (Resident 57 and 41) Findings include: 1. The clinical record for Resident 57 was reviewed on 8/2/22 at 12:11 p.m. The Resident's diagnosis included, but were not limited to, diabetes and anxiety. He was admitted to the facility on 9/28/21. A care plan, initiated 9/29/21 and last revised on 5/17/22, indicated that he had signs and symptoms of anxiety like restlessness, agitation, and excessive worrying and paranoia. The goal, last revised on 11/5/21, was that his symptoms will be managed through use of the care plan interventions. The interventions included, but were not limited to, allow me to ventilate my anxiety as needed, initiated 9/29/21, reassurance as needed, initiated 9/29/21, remind me of using relaxation strategies such as massage, talk in soothing voice, soft music, sounds, deep breathing, initiated 9/29/21, when I am anxious, and reapproach later for completion of tasks, initiated 9/29/21. An Admission MDS (Minimum Data Set) Assessment, completed 10/4/21, indicated he was cognitively intact and that it was very important for him to take care of his personal belongings and to have a place to lock his things and keep them safe. His mood score was 3, indicating		following corrective measures: 1. Resident #57's refrigerator is functioning properly and is utilized by the resident effectively. His laptop functions well and is utilized by the resident daily, as is his phone and television. All grievances have been investigated to the fullest extent possible. His wound was treated and has shown no deterioration. He has been informed of his right to a copy of completed grievance forms and will be provided with a copy when requested. Staff continue to provide care in pairs. Resident #41 has been measured by therapy and a new wheelchair has been ordered. 2. All residents have the potential to be affected. See below for corrective measures. 3. The Grievance procedure was reviewed and no changes were indicated. Staff will be re-educated on the procedure. The regional director or his designee will review 5 random grievances weekly for 6 week and until 100% compliance is achieved, then 10 random grievances monthly for 6 months and until 100% compliance is maintained. 4. The findings of these reviews will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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possible signs of minimal depression

A care plan, initiated 10/4/21 and last revised on 5/17/22, indicated he had behavioral symptoms such as having an unrealistic need to control his environment. He had a history of making frequent false allegations against the staff and exhibited paranoid behaviors. The goal, last revised on 11/5/21, was for his behavioral symptoms would be managed through care plan interventions as evidenced by having less than 3 episodes per week. The interventions included, but were not limited to, allow me to express my feelings, initiated 10/4/21, mental health services as indicated, initiated 10/4/21, offer me alternative care choices to achieve the same outcome, initiated 10/4/21, staff to provide care for me in pairs, initiated 11/5/21.

An Initial Psychiatric Evaluation, dated 10/6/21, indicated that he was referred by social services and was stable with no new issues. He reports that he is "fine". He was a new admission to the facility. He denied any feelings of sadness, depression, or anxiety at this time. He was in good spirits and was open to seeing someone from psych on an as needed basis. He was made aware to inform social services if behavioral health services are needed.

A Quarterly MDS Assessment, completed 4/10/22, indicated he was cognitively intact and able to make himself understood and to understand what was being said to him. His mood score was 0, indicating no signs of possible depression.

A psychiatric health provider follow up evaluation note, dated 5/24/22, indicated that he was referred by social services for an acute issue and ongoing issues.

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A Quarterly MDS Assessment, completed on 6/17/22, indicated he was cognitively intact and was able to make himself understood and to understand what was being said to him. His mood score was 12, indicating signs of possible moderate depression.

During an interview on 8/2/22 at 12:22 p.m., Resident 57 indicated that he had brought concerns about missing and damaged items, the staff being disrespectful and making derogatory verbal comments to him, and that his bank account, cell phone, and computer had been hacked to the social services director and had not received any resolution to his concerns. He felt that the staff were dismissive of any concern he had.

On 8/3/22 at 9:30 a.m., the ED (Executive Director) provided a grievance from 10/28/21, which was a concern about a staff member being disrespectful and yelling at Resident 57. The grievance had been investigated as a possible abuse allegation and was found to be unsubstantiated.

During an interview on 8/04/22 at 1:46 p.m., Resident 57 indicated he felt that his bank account had been hacked due to some transaction from a grocery store that had not been authorized and he had not received the good that had been ordered using his name and debit card. The bank had frozen his accounts due to the concern. He needed to go to the bank to unfreeze the accounts but was having trouble with transportation. He also needed a valid ID when he went to the bank and his driver's license had expired. He had been unable to pay his bill at the facility since June 2022. When he brought concerns up, he was frequently told that the concerns were not the

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facilities concern. He had asked the facility for assistance obtaining a new driver's license many times and explained that it was needed to unfreeze his bank account. Being in this position was embarrassing to him. The facility had offered to assist with making arrangements for him to look for placement at another facility multiple times. He did not want to move to a different facility because he had made such gains with the facilities therapy department. He was open to doing anything to be able to stay at the facility.

During an interview on 8/4/22 at 2:59 p.m., the ED, NC (Nurse Consultant) and the DON (Director of Nursing) indicated that he frequently made false allegations and there were no further grievances for Resident 57. The only grievance had been the one in October 2021.

During an interview on 8/5/22 at 3:16 p.m., the SSD (Social Services Director) indicated she remembered that shortly after she began working at the facility, he had voiced a concern about a CNA (Certified Nursing Assistant) intentionally bumping into his chair and completing a grievance of the event. He had voiced concerns on multiple occasions about his computer and cell phone being hacked. He was also concerned that the "smart" tv in his room had been hacked. He had a history of making false accusations. She felt he may have seen things on the television and adapted them into his personal situation. The Corporate IT (Information Technology) department had looked into the concerns of hacking and did not find that the building had been hacked in any way. She did have several other grievance forms which had been completed for him.

On 8/8/22 at 10:26 a.m., the ED provided 3

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additional grievance forms for Resident 57.

A Grievance form, dated 3/11/22, was identified as being re-written due to the previous form being lost. It indicated the grievance as dents in Resident 57's personal refrigerator, gas in water bottles, his laptop had been hit by someone, and that a care giver had tried to steal a ring off of his finger. The departments who were responsible for investigating the grievance and following up were Administer and Social Services. The investigation was that the water bottles had been inspected and all were sealed and not tampered with. Damaged property cannot be determined to be damaged by staff and that he had signed admission packet stating damaged or lost property was not the responsibility of the facility. All staff were to provide care in pairs due to false allegations and resident behaviors. The findings / conclusions were that the complaints were not substantiated at that time. Resident 57 was offered assistance transferring to another facility and he declined due to liking the therapy department. A copy of the grievance had not been given to the him because he had not requested a copy.

A Grievance form. dated 4/6/22, described that Resident 57 reported that a CNA had followed him down the hall and bumped into his wheelchair. He felt this was due to him not liking her boyfriend. The department responsible for investigating the grievance was the nursing department. The investigation was that the suspected CNA was not in the building on the date the occurrence allegedly happened. The video cameras were reviewed and the CNA in question was not seen on the hallway. She had not been in the facility since 3/22/22. Resident 57 reported that he must have been dreaming. A copy of the grievance had

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	not been given to the him because he had not requested a copy. A Grievance form, dated 6/1/22, which indicated that a nurse with long braids and nails had come into his room around 7:00 a.m. with his medications. He had informed the nurse that he needed to have a bowel movement and the nurse said to him "I don't' deal with that'. A CNA had come to help him to the toilet. He had requested that a new bandage be applied to his wound because the current one would not stay on. The nurse had said she did not do wound care. He had been told by the nurse "I'm not your child or your (expletive) and the nurse had left the room. He had also reported being hacked on a social media app. The departments responsible for the investigation were nursing and social services. The investigation was that Resident 57 reported that the treatment was completed by the nurse. He denied referring to the nurse as the (expletive). He went on the say that he had been hacked and received an email from a social media app endorsing that black people are "ruining America" and sound byte of the President but could not find the video in his computer. The findings / conclusion were that the nurse was in the middle of medication pass and got the caregiver to provide care promptly. The treatment was completed. Social Services had addressed the social media app hacking with Resident 57. He could not locate the app on his phone. He did not appear to have an account and the video could not be located. The grievance was not confirmed. The resolution was that he was informed of the follow up and no further grievances were voices. He reported being confused about the social media hack and indicated that all evidence of the hack had disappeared. A copy of the grievance had not been provided to the resident because he			

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had not requested a copy.

During an interview on 8/8/22 at 4:12 p.m., Resident 57 indicated that his personal refrigerator used to set on the floor. The staff would run into the front of it with the mechanical full body lift when they transferred him to and from bed. It had become scratched and had multiple dents on the front of it. He had bought the refrigerator brand new and liked to keep his things nice. It had upset him when the staff ran into it and felt they were not being respectful of his belongings. His computer been knocked off of the table when a nurse bumped into it with her "bottom" while providing care. He had informed the previous social services director and she had not gotten back with him. The facility had never offered to replace anything that was broken or damaged. He was unaware that he had signed a document upon admission which prevented him from holding the facility accountable for missing or broken items. If he had known, he would not have signed it. He had not been told that he could request a copy of the grievance resolution. If he would have known, he would have requested copies.

During an interview on 8/8/22 at 4:48 p.m., the ED indicated that his grievances had been addressed by the former and current SSD and the former Administrator in Training. Resident 57 did not know what had happened to his laptop. The facility could not prove that the staff actually damaged it and it could have been brought to the facility with scratches and dents or that he could have run into it with his electric wheelchair and caused the dents. The admission agreement does indicate that the facility is not responsible, but if we investigated and found staff had done something then we would have addressed the issue. The facility had offered him assistance in

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relocating to a different facility many times.

During an interview on 8/9/22 at 9:46 a.m., OT (Occupational Therapist) 12 indicated that she felt he had displayed less paranoia that in the past. He had brought up concerns, but usually spoke with them in general terms and did not offer specifics. He struggled with changes and needed redirection often. He responded well when the therapy staff encouraged him to focus on the things he could change and control. There were no concerns with how he operated his electric wheelchair. She had never seen him run into anything with it and he was very cautious and displayed very good safety awareness when operating it.

During an interview on 8/9/22 at 10:09 a.m. PT (Physical Therapist) 25 indicated he had brought up concerns to him about his devices being hacked. When Resident 57 brought up those types of concerns, he would redirect him to focusing on his therapy and toward things he does have control over. His ability to recall information was good, he was able to recall conversations was good. He had not noted any cognitive issues with Resident 57 since his return from his most recent hospitalization about a month and a half ago. He felt he was at his baseline.

During an interview on 8/9/22 at 10:27 a.m., the SSD indicated Resident 57 had brought up needing a new driver's license around 7/18/22. She had worked with him to start an application for public transit services. When he displayed paranoia, she would talk with him and try to help him sort things out. She recalled the grievance which was filed on 6/1/22 and that nursing had done the majority of the investigation. She did

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not see that the statement the nurse had made toward him was addressed on the grievance form. Resident 57 had been questioned about using racial slurs, but that was not what the concern was about.

During an interview on 8/9/22 AT 11:05 a.m., the DON (Director of Nursing) indicated that she did not investigate the grievance but was aware of the investigation. The nurse who had completed the investigation was currently on leave. The nurse mentioned in the grievance has been talked to and had indicated that he had called her the racial slur. She had reported that she redirected him by telling him that what he said was not nice and what her name was. She did not have any documents, other than the grievance form, which detailed the investigation of the 6/1/22 grievance and that it would have been helpful for that information to be placed on the grievance form.

On 8/9/22 at 8:45 a.m., the ED provided the Inventory Sheet of Resident 57's personal belongings, which indicated the refrigerator have been brought into the facility on 1/30/22.

During an interview on 8/9/22 at 3:03 p.m., the psychiatry councilor indicated she had seen him 3 times. She had done his intake assessment on 7/18/22. She was working with him on dealing with his anxiety. He had a diagnosis of adjustment disorder. His form of thoughts was logical, he did appear apprehensive and irritable. He had told her about his devices being hacked and that he had contacted the police who had told him to contact the FBI and Homeland Security, which he had done. She had been concerned that some mental health issues could be going on, so she researched what should be done if someone suspected there computer had been hacked. She

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found that the recommended course of action was to contact the FBI.

During an interview on 8/9/22 at 3:23 p.m., the SSD indicated that when she went over grievances with a resident, she did not ask residents if they would like a copy. She knew that the right to obtain a copy of the grievance form was posted in the building. She did not inform them of their right to have a copy verbally. She would normally only give a copy if requested.

2. The clinical record for Resident 41 was reviewed on 8/2/22 at 11:45 a.m. The diagnoses included, but were not limited to, chronic pain. He was admitted to the facility on 10/27/21.

The 12/3/21 Inventory sheet indicated he had several articles of clothing, a gray cane, a walker, a bed side commode, and a black wheel chair.

The 6/9/22 Quarterly MDS assessment indicated he had a BIMS (brief interview for mental status score) of 15, indicating he was cognitively intact.

An observation was made on 8/2/22 at 11:47 a.m. in Resident 41's room. He was lying in bed. There was a black wheel chair with a blue seat cushion in his room that had a left foot pedal with a calf rest.

An interview was conducted with Resident 41 on 8/2/22 at 11:47 a.m. He indicated the wheel chair in his room was not his wheel chair and was "way too small" for him. He slid right out of it. He brought his own folding wheel chair to the facility from home, but it went missing when staff took it to clean it at the end of February, 2022, and he never got it back.

An interview was conducted with Resident 41 on

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8/4/22 at 11:07 a.m. He indicated he'd spoken to the DON (Director of Nursing,) SSD (Social Services Director,) and an "endless" amount of nursing staff about his missing wheel chair. Staff have known about the missing wheel chair ever since it went missing. His wheel chair was wider and taller than the one currently in his room, and he was able to sit in his.

An interview was conducted with LPN (Licensed Practical Nurse) 8 and UM (Unit Manager) 2 on 8/4/22 at 11:25 a.m. LPN 8 indicated Resident 41 had told nursing about a missing wheel chair, but no one knew anything about a missing a wheel chair, and it was "one of the stories he tells." UM 2 indicated if he had a wheel chair that went missing, they would have been able to find it, because it would be bigger and "it wouldn't blend in. You'd know."

An interview was conducted with the PTD (Physical Therapy Director) on 8/5/22 at 1:45 p.m. She indicated Resident 41's family brought in a personal wheel chair for him a couple of months after he admitted.

An interview was conducted with OT (Occupational Therapist) 12 on 8/5/22 at 1:55 p.m. She indicated when Resident 41 discharged from therapy in December, 2021, he had 2 wheel chairs in his room, a high back wheel chair with which he discharged from therapy and his personal wheel chair.

An interview was conducted with the SSD on 8/4/22 at 3:12 p.m. She indicated she'd talked to Resident 41 about his missing wheel chair quite a bit. There was a grievance filed on it, and she spoke with therapy about it, but was unsure of the resolution.

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On 8/8/22 at 10:27 a.m., the ED provided the 3/18/22 Grievance Form for Resident 41's missing wheel chair. It read, "Description of Grievance: personal wheel chair is missing. He reports that staff took the wheel chair one night to clean it and he never got it back. He is asking for his wheel chair to be replaced with a w/c [wheel chair] that fits him." The Investigation section of the grievance form read, "Staff do not recall what happened. They thought they returned all wheel chairs to each resident. [Name of Resident 41] advised his w/c has his name engraved underneath and on the sides in silver and black marker. Unit searched and all other chairs looked at for the markings described to identify the chair." The Findings/Conclusions section of the form read, "Was not able to locate a black w/c that fits description given by [name of Resident 41.] [Name of Resident 41] was provided a wheel chair that fits him and is in good working order for his daily use." The Resident/Resident Representative Response to Resolution section of the grievance form read, "Unable to locate w/c as resident describes. Provided w/ [with] w/c per therapy, properly fitting."

On 8/9/22 at 2:44 p.m., the SSD provided the 3/18/22 Grievance Form for Resident 41's missing wheel chair with a different Resident/Resident Representative Response to Resolution section. This form's section read, "A chair was provided until his chair was located. He didn't want a permanent replacement. He only wants his chair and was open to a temp [temporary] replacement."

An interview was conducted with LPN 8 on 8/5/22 at 10:57 a.m. at the nurse's station. She indicated Resident 41 had an appointment today at 12:30 p.m., so therapy provided him with a new wheel

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chair, since he would be traveling out of the facility. The back on the wheelchair that had been in his room was too low, per Resident 41.

On 8/5/22 at 10:57 a.m., CNA (Certified Nursing Assistant) 9 approached the nurses station and informed LPN 8 that the chair provided by therapy today would not lock. LPN 9 instructed CNA 8 to have therapy show her how to use it.

On 8/5/22 at 11:06 p.m., CNA 9 approached the nurses station again and informed LPN 8 the back of the wheel chair given to Resident 41 today wasn't sitting up properly. LPN 8 left the nurses station to check on Resident 41 and then returned to the nurse's station. Upon return, LPN 8 indicated Resident 41 insisted the newest chair wasn't supporting his legs, so they were going to get him another wheel chair.

An observation and interview was conducted with Resident 41 on 8/5/22 at 11:28 a.m. in his room. He was alone in his room, sitting in a high back wheel chair. Both of his feet were resting on the extended left foot pedal of the wheel chair. The right foot pedal did not match the left foot pedal as it did not extend outward, like the left one. There was another high back wheel chair behind him with no foot pedals. Resident 41 indicated he was uncomfortable in the chair and stated, "They just left me like this." On 8/5/22 at 11:34 a.m., CNA 10 entered the room. CNA 10 indicated the right foot pedal was broken and didn't work. Resident 41 informed everyone in the room he was agitated and not prepared for his appointment. His legs were uncomfortable and his back hurt. The bus driver, who was taking Resident 41 to his appointment, entered the room. The bus driver indicated Resident 41 informed him at 8:30 a.m. this morning that the wheel chair in his

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room was uncomfortable, so he asked nursing for another wheel chair. On 8/5/22 at 11:43 a.m., CNA 11 entered the room and repositioned Resident 41 in the wheel chair in which he was currently sitting. While adjusting him, both of his feet came off of the left foot pedal. Then the bus driver, who had since exited the room, reentered the room with a matching right foot pedal. Then UM 2 entered the room with LPN 8. UM 2 announced, "We have 10 minutes to figure this out."

An interview was conducted with the PTD (Physical Therapy Director) on 8/5/22 at 1:45 p.m. She indicated Resident 41 was currently on physical therapy caseload, as of last week. He was evaluated on 7/27/22 and scheduled for 3 times weekly for 30 days. A CNA came to see her about 10:45 a.m. today, informed her Resident 41 had an appointment, and they couldn't lock the high back wheel chair. The PTD went to look at it. It wasn't engaging enough, so she provided another high back wheel chair, and informed nursing if it didn't work, his appointment may have to be canceled. Everyone needed a way to go out, in general. A stretcher could relieve a lot of issues. She didn't find out about him having an appointment to go out to until today at 10:45 a.m. If nursing wanted therapy's opinion on how to transport a resident out, they would give it, but they didn't consult on every resident.

An interview was conducted with Resident 41 on 8/5/22 at 2:30 p.m. He indicated he want his wheel chair back or reimbursement.

An interview was conducted with the SSD on 8/8/22 at 2:45 p.m. She indicated in March, 2022, Resident 41 seemed okay with the resolution, but over time "not so much."

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	On 8/8/22 at 10:33 a.m., the ED provided a copy of the current Grievance Policy, last revised November 2021, which read "... Policy: It is the policy of this facility to thoroughly investigate all grievances and provide a prompt resolution regarding the resident's rights. The facility respects the resident's/ resident representative's right to file a grievance and can do so without fear of reprisal or mistreatment...1. The facility will notify residents/ resident representative individually or through postings located in prominent areas throughout the facility...4. The facility will, as necessary, take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated. 5. The facility will ensure that all written grievance decisions include: a. the date the grievance was received, b. A summary statement of the resident's grievance, c. steps taken to investigate the grievance, a summary of the pertinent findings; or d. Conclusions regarding the resident's concern(s), e. A statement as to whether the grievance was confirmed or not confirmed, f. Any corrective action take or to be taken by the facility as a result of the grievance, g. the date the written decision was issued...12. Within 5 business days of the date the Grievance form was filed, the Grievance Official will inform the resident/ resident representative of the results of the investigation. The resident/ resident representative will be informed of their right to obtain a written copy of the grievance decision and it will be provided at the resident/ resident representative's request..." 3.1-7(a)(1) 3.1-7(a)(2) 3.1-7(b)			

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F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to timely report an allegation of abuse for 1 of 4 residents reviewed for abuse. (Resident 5) Findings include: The clinical record for Resident 5 was reviewed on	F 0609	The facility will ensure this requirement is met through the following corrective measures: 1. Once the surveyor reported that she felt the grievance was a report of abuse, the incident was report via Gateway to IDOH as a	09/07/2022

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	8/3/22 at 2:26 p.m. The diagnoses for Resident 5 included, but were not limited to, type 2 diabetes mellitus and anxiety. An annual Minimum Data Set (MDS) assessment, dated 4/22/22, indicated Resident 5 was cognitively intact. A care plan dated 6/25/21, revision on 3/9/22 indicated "I [Resident 5] display the following behavior [refusing back brace] Embellishing situations in an effort to seek attention." A care plan dated 9/2/21 indicated "I have behavioral symptoms such as (exhibiting anxious behaviors to gain attention, I will go to multiple staff members with fictitious complaints toward other staff, I will make complaints to multiple staff members even when they have been addressed. I have a diagnosis of Anxiety, insomnia, and Major Depressive D/O [disorder] recurrent mild, Mood D/O due to known physiological condition with depressive features. A grievance form dated 6/20/22 indicated "...Grievance: During incontinence care the water felt hotter than normal. The CNA was tall and light skin and the other aid...Investigation: The CNA said she did not think the water was hot it felt the same as normal. No redness noted to skin upon nurse assessment. Findings/Conclusions: Water temp [temperatures] randomly checked. All temps within normal temperature ranges. Water temps checked weekly. Randomly throughout the week. Skin rechecked 6/21/22 [symbol "0" with line through it] redness noted...Resolution. No further concerns, maintenance director talked to resident, and she voiced no further concerns..." An interview was conducted with Resident 5 on		reportable incident. The incident was reinvestigated to the fullest extent possible. The surveyors were provided copies of those investigations once completed during the survey. Two staff members were present at the time of the incident. The resident was not harmed. There was no intent to harm. Water temps were checked and within regulatory range required. 2. All residents have the potential to be affected. See below for corrective measures. 3. The Abuse policy was reviewed and no changes were indicated. The ED, DCS and ADCS will be re-educated on the abuse policy, specifically reporting of allegations. The regional director will review 5 random grievances weekly and all new abuse allegations weekly to ensure all potential abuse allegations are reported timely to IDOH for 6 weeks and until 100% compliance is achieved, then 10 random grievances and all abuse allegations monthly for 6 months and until 100% compliance is maintained. 4. The findings of these reviews will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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8/2/22 at 11:46 a.m. She indicated she had been abused by a CNA during care. Approximately a month to month in half ago, a CNA (Certified Nursing Assistant) had burnt her private areas during a shower. The water was too hot. As soon as the water was on her privates she jerked back. The staff are aware and assessed her skin after. The CNA has not worked with her since the incident. She had also discussed what had happened during a care plan meeting recently with the presence of Ombudsman 5. Ombudsman 5 had typed up a paper with concerns discussed at the meeting. At that time, the resident provided a paper titled, "Care Plan Meeting for [Resident 5] dated 7/19/22. Concerns [Resident 5] may want to discuss:...4) physical abuse (hot water on genitals during shower care)..."

An interview was conducted with the Director of Nursing (DON) and the Executive Director (ED) on 8/2/22 at 3:45 p.m. The DON indicated there was a grievance written by nursing from Resident 5 regarding the water temperature was too hot during incontinent care. The ED indicated a skin assessment was conducted and water temperatures were checked. The resident at that time had not indicated she was abused, so it had not been reported. The ED stated she would report to Indiana Department of Health.

An interview was conducted with the Social Services Director on 8/4/22 at 2:04 p.m. She indicated a care plan meeting had been conducted with Resident 5 on 7/19/22. Ombudsman 5 and ED was also present at that meeting. During that meeting, the resident had spoken about the care that had been provided during incontinence care, and the water was too hot. The resident was upset when she had spoken about the incident and was not happy with the care that had been provided at

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that time. The resident described the incident as the CNA had wrung the wash cloth out and hot water had landed on her genitals. The SSD indicated the resident had not stated she felt abused nor had she asked if the resident felt she had been abused.

An interview was conducted with Ombudsman 5 on 8/4/22 at 4:09 p.m. He indicated he had been present during a care plan meeting with Resident 5 on 7/19/22. The ED also was present during the meeting. The resident was upset while discussing the incident regarding the incontinence care, with the hot water. The staff at that time, indicated the incident had already been investigated.

An abuse policy was provided by the ED on 8/2/22 at 1:55 p.m. It indicated "...Policy: This facility's policy is the resident has the right to be from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment and misappropriation of resident property in accordance with all stated (sic) and federal regulations. Resident must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. Purpose: This policy's purpose is to ensure that resident rights are protected by providing a method for investigation and reporting of allegations of mistreatment, neglect, abuse, including injuries of unknown source, unusual occurrences and misappropriation of resident property. Definitions: Abuse: the willful infliction of injury, unreasonable confinement, intimidations or punishment with resulting physical pain or mental anguish...Neglect: This occurs on an individual basis when a resident is not cared for in one or

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	more areas. Neglect is also lack of attentiveness, carelessness or failure to provide timely, consistent, safe, adequate services, treatment and care, including but not limited to:..activities of daily living. The absence of reasonable accommodation of individual needs and preferences may result in neglect. And neglect is the failure to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress...7. The facility will ensure that all allegations of mistreatment, neglect or abuse, including injuries of unknown source, are reported immediately to the Administrator of the facility and to other officials in accordance with federal/state law through established procedures. The Administrator and/or other officials shall notify State officials in accordance with guidelines which according to CMS [The Centers for Medicare and Medicaid Services] Federal guidelines...(i) Report all alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property immediately but not later than 2 hours. (ii) If no serious bodily injury; or does not involve abuse, report not later than 24 hours..." 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while			

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	the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse timely for 1 of 4 residents reviewed for abuse. (Resident 5) Findings include: The clinical record for Resident 5 was reviewed on 8/3/22 at 2:26 p.m. The diagnoses for Resident 5 included, but were not limited to, type 2 diabetes mellitus and anxiety. An annual Minimum Data Set (MDS) assessment, dated 4/22/22, indicated Resident 5 was cognitively intact. A care plan dated 6/25/21, revision on 3/9/22 indicated "I [Resident 5] display the following behavior [refusing back brace] Embellishing situations in an effort to seek attention." A care plan dated 9/2/21 indicated "I have behavioral symptoms such as (exhibiting anxious behaviors to gain attention, I will go to multiple staff members with fictitious complaints toward other staff, I will make complaints to multiple staff members even when they have been addressed. I have a diagnosis of Anxiety, insomnia, and Major Depressive D/O [disorder] recurrent mild, Mood D/O due to known physiological condition with	F 0610	1. Once the surveyor reported that she felt the grievance was a report of abuse, the incident was report via Gateway to IDOH as a reportable incident. The incident was reinvestigated to the fullest extent possible. The surveyors were provided copies of those investigations once completed during the survey. Two staff members were present at the time of the incident. The resident was not harmed. There was no intent to harm. Water temps were checked and within regulatory range required. 2. All residents have the potential to be affected. See below for corrective measures. 3. The Abuse policy was reviewed and no changes were indicated. The staff will be re-educated on the abuse policy. The regional director will review 5 random grievances weekly and all new abuse allegations weekly to ensure all potential abuse allegations are reported timely to IDOH and investigated thoroughly for 6 weeks and until 100%	09/07/2022

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	depressive features. An interview was conducted with Resident 5 on 8/2/22 at 11:46 a.m. She indicated she had been abused by a CNA (Certified Nursing Assistant) during care. Approximately a month to month in half ago, a CNA had burnt her private areas during a shower. The water was too hot. As soon as the water was on her privates she jerked back. The staff are aware and assessed her skin after. The CNA has not worked with her since the incident. She had also discussed what had happened during a care plan meeting recently with the presence of Ombudsman 5. Ombudsman 5 had typed up a paper with concerns discussed at the meeting. At that time, the resident provided a paper titled, "Care Plan Meeting for [Resident 5] dated 7/19/22. Concerns [Resident 5] may want to discuss:...4) physical abuse (hot water on genitals during shower care)..." An interview was conducted with the Director of Nursing (DON) and the Executive Director (ED) on 8/2/22 at 3:45 p.m. The DON indicated there was a grievance written by nursing from Resident 5 regarding the water temperature was too hot during incontinent care. The ED indicated a skin assessment was conducted and water temperatures were checked. An interview was conducted with the Social Services Director (SSD) on 8/4/22 at 2:04 p.m. She indicated a care plan meeting had been conducted with Resident 5 on 7/19/22. Ombudsman 5 and ED was also present at that meeting. During the meeting, the resident had spoken about the care that had been provided during incontinence care, and the water was too hot. The resident was upset when she had spoken about the incident and was not happy with the care that had been provided at		compliance is achieved, then 10 random grievances and all abuse allegations monthly for 6 months and until 100% compliance is maintained. 4. The findings of these reviews will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. The facility will ensure this requirement is met through the following corrective measures:	

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that time. The resident described the incident as the CNA had wrung the wash cloth out and hot water had landed on her genitals.

An interview was conducted with Ombudsman 5 on 8/4/22 at 4:09 p.m. He indicated he had been present during a care plan meeting with Resident 5 on 7/19/22. The ED also was present during the meeting. The resident was upset while discussing the incident regarding the incontinence care, and the hot water. The staff at that time, indicated the incident had already been investigated.

A grievance form dated 6/20/22 indicated "...Grievance: During incontinence care the water felt hotter than normal. The CNA was tall and light skin and the other aid has a tiger tattoo on her face...Investigation: The CNA said she did not think the water was hot it felt the same as normal. No redness noted to skin upon nurse assessment. Findings/Conclusions: Water temp [temperatures] randomly checked. All temps within normal temperature ranges. Water temps checked weekly. Randomly throughout the week. Skin rechecked 6/21/22 [symbol "0" with line through it] redness noted...Resolution. No further concerns, maintenance director talked to resident, and she voiced no further concerns..."

The grievance form and the investigation was provided by the ED on 8/2/22 at 4:00 p.m. It included the following: grievance form, resident room numbers and water temperatures obtained, and
Resident 5's skin assessment dated 6/21/22.

The investigation did not include the following: statements by both described CNAs providing the incontinent care, (CNA 23 and CNA 24), and interviews by other staff and residents

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	An interview was conducted with the SSD on 8/9/22 at 2:46 p.m. The SSD indicated Resident 5's grievance and the investigation that was provided was the completed investigation at that time. After the incident was reported to Indiana State Department of Health on 8/2/22, a new investigation was being conducted. An abuse policy was provided by the ED on 8/2/22 at 1:55 p.m. It indicated "...Policy: This facility's policy is the resident has the right to be from verbal, sexual, physical and mental abuse, involuntary seclusion, corporal punishment and misappropriation of resident property in accordance with all stated (sic) and federal regulations. Resident must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. Purpose: This policy's purpose is to ensure that resident rights are protected by providing a method for investigation and reporting of allegations of mistreatment, neglect, abuse, including injuries of unknown source, unusual occurrences and misappropriation of resident property...10. The facility will keep evidence that all alleged violation are thoroughly investigated and will prevent further potential abuse while the investigation is in the process..." 3.1-28(d)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a			

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resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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	§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the			

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	facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on interview and record review, the facility failed to timely provide the long-term care ombudsman with notice of a facility-initiated transfer or discharge for 1 of 2 residents reviewed for discharge (Resident 57). Findings include: The clinical record for Resident 57 was reviewed on 8/2/22 at 12:11 p.m. The Resident's diagnosis included, but were not limited to, diabetes and anxiety. A Quarterly MDS Assessment, completed on 6/17/22, indicated he was cognitively intact and was able to make himself understood and to understand what was being said to him. During an interview on 8/2/22 at 12:12 p.m., Resident 57 indicated he had been given a 30-day notice by the facility for non-payment. He was given the notice on 7/19/22 and the effective date of his discharge was 8/18/22. He had not filed an	F 0623	The facility will ensure this requirement is met through the following corrective measures: 1. The Ombudsman attended the resident's discharge planning meeting which was conducted during the course of the IDOH survey. 2. Any resident who may receive a facility-initiated notice of transfer or discharge would have the potential to be affected. There are no residents meeting that criteria at this time. 3. The Notice of Transfer or Discharge Policy was reviewed and no changes are indicated. Social services staff will be re-educated on this policy. The administrator or her designee will review weekly to ensure the Ombudsman is notified of any facility-initiated transfer/discharge for 6 weeks and until 100%	09/07/2022

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	appeal timely but was having a meeting with the ombudsman and the facility, to discuss his options, on 8/4/22. During an interview on 8/4/22 at 3:52 p.m., Ombudsman 5 indicated the Notice of Transfer or Discharge had not been received by his office. The facility was required to inform the Long-Term Care Ombudsman when issuing a 30-Day notice. During an interview on 8/5/22 at 2:30 p.m., the Nurse Consultant indicated there was no documentation in the medical record that the Notice of Transfer or Discharge had been sent to the Long-Term Care Ombudsman when it was issued or that Resident 57's physician had been made aware of the notice. The Ombudsman's office should have been notified. On 8/8/22 at 4:25 p.m., the Executive Director provided the Notice of Transfer or Discharge Policy, last revised June 2021, which read "...It is the policy this facility to assist with resident as directed by the Administrator should a Notice of Transfer or Discharge become necessary...8. The nursing facility must place a copy of the notice in the resident's medical record and transmit/ provide a copy to the following...d. The local Long-Term Care Ombudsman program for any facility-initiated transfer...e. The person or agency responsible for the resident's placement, maintenance, and care in the facility...g. The resident's physician when the transfer or discharge is necessary due to ...111. The resident has failed, after reasonable and appropriated notice, to pay for (or have paid under Medicate or Medicaid) a stay in the facility...h. Record the reason in the medical record..." 3.1-12(a)(6)(A)		compliance is achieved, then monthly for 6 months and until 100% compliance is maintained. 4. The findings of these reviewed will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.			
	Based on observation, interview, and record review, the facility failed to ensure accuracy of a resident's MDS (Minimum Data Set) assessment for 1 of 4 residents reviewed for dental services and 1 of 2 residents reviewed for Preadmission Screening and Resident Review (PASRR), (Resident 41 and 67). Findings include: 1. The clinical record for Resident 41 was reviewed on 8/2/22 at 11:45 a.m. The diagnoses included, but were not limited to, chronic pain. He was admitted to the facility on 10/27/21. The 11/5/21 Admission MDS assessment indicated he did not have any obvious or likely cavities or broken natural teeth. The 6/9/22 Quarterly MDS assessment indicated he had a BIMS (brief interview for mental status score) of 15, indicating he was cognitively intact. An observation and interview was conducted with Resident 41 on 8/2/22 at 11:58 a.m. He opened his mouth and had several missing teeth, broken teeth, and brownish black teeth on top and bottom. He indicated he took 7 or 8 pills at a time, when taking his medication, and some of the pills would get stuck in the cavities in his mouth. After taking his medication, an hour or two later, a pill would fall out of a tooth. His teeth were cutting into his gums, and it was causing him pain.	F 0641	The facility will ensure this requirement is met through the following corrective measures: 1. A correction will be completed for both residents #41 and #67. 2. All residents have the potential to be affected. See below for corrective measures. 3. The facility utilizes the RAI manual for procedures. MDS staff will be educated on the importance of accuracy when completing the MDS. The MDS Consultant or his designee will review 3 random MDS submissions weekly for accuracy for 6 weeks and until 100% compliance is achieved, then 5 per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	09/07/2022

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An interview was conducted with the Case Manager in the MDS office on 8/4/22 at 2:18 p.m. She indicated she assisted with MDS assessments. The nurse who completed the dental section of Resident 41's 11/5/22 Admission MDS assessment was a nurse navigator who went to several facilities and conducted MDS assessments.

An observation of Resident 41's oral cavity was made with the Case Manager and RN (Registered Nurse) 15 on 8/4/22 at 2:29 p.m. The Case Manager indicated she saw a broken tooth in the front of his mouth. Resident 41 informed the Case Manager and RN 15 the pain came from the cuts in his mouth, if he took a cold drink, ate something hot, chewing, biting his lip, teeth cutting into his gums, trying to close his mouth, and clenching his teeth. He stated, "It's just not good, you know."
2.The clinical record for Resident 67 was reviewed on 8/2/22 at 2:28 p.m. The diagnosis for Resident 67 included, but was not limited to, depressed mood.

A PASRR Level I Screen for Resident 67 dated 8/21/21 indicated level II was not required. The level I had record of a diagnosis Adjustment Disorder with depressed mood. The screen indicated if changes occur a new screen must be submitted.

An admissions Minimum Data Set (MDS) assessment, dated 8/23/21, indicated Resident 67 did not have a psychotic disorder.

An annual MDS assessment, dated 6/24/22, indicated Resident 67 was diagnosed with depression and a psychotic disorder.

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	An interview was conducted with the Nurse Consultant on 8/9/22 at 4:00 p.m. She indicated after reviewing Resident 67's clinical record, she was unable to locate any diagnosis of a psychotic disorder. The annual MDS was incorrect. 3.1-31(d)			
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting			

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	paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			
	Based on interview and record review, the facility failed to inform the resident and/or their representative of the baseline care plan nor provided a written summary of the baseline care plan as evidenced by the clinical record not containing evidence the summary was given to the resident and/or resident representative for 1 of 4 residents reviewed for care plans. (Resident 80) Findings include: The clinical record for Resident 80 was reviewed on 8/5/22 at 1:53 p.m. Resident 80's diagnoses included, but not limited to, heart failure, cognitive communication deficit, diabetes type II, and muscle weakness. Resident 80 was admitted to the facility on 7/1/22. Resident 80's clinical record did not contain evidence the baseline care plan was reviewed with Resident 80 nor her representative. An interview with MDSC (Minimum Data Set Coordinator) was conducted on 8/05/22 at 2:22 p.m. MDSC indicated, she and the Case Manager	F 0655	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. Resident #40 and her responsible party were provided a copy of thee baseline care plan. 2. All newly admitted residents have the potential to be affected. All residents admitted in the last 14 days were reviewed to ensure a copy of the baseline care plan was received. 3. The Care Planning policy was reviewed and no revisions were indicated. The Interdisciplinary team (IDT) was re-educated on this policy. The HFA or her designee will review 3 new admissions weekly to ensure there is documentation that a copy of the baseline care plan was provided to the resident/family for 6 weeks and until 100% compliance is achieved, then 5 per	09/07/2022

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	are responsible for the baseline and comprehensive care plans. MDSC further indicated, she could not identify when or if the baseline care plan was reviewed with Resident 80 and/or her representative in the clinical record. A Care Planning policy was received on 8/5/22 at 2:22 p.m. from ED (Executive Director). The policy indicated, "Baseline Plan of Care...5. The resident/resident representative will receive at least a summary of the Baseline Plan of Care...6. The Baseline Care Plan summary will be covered in the Living Well meeting and documented in the Electric Health Record." 3.1-30(a)		month for 6 months and until 100% compliance is maintained. 4. The findings of these reviews will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care			

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	plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to revise a resident's care plan to address her refusal of medication, to revise a resident's care plan to reflect the current needs of the resident and to ensure care plan meetings were conducted with the participation of residents and/or resident's representatives for 1 of 4 residents reviewed for nutrition and 3 of 3 residents reviewed for care planning (Resident 26, 67, 80 and 88). Findings include: 1. The clinical record for Resident 88 was reviewed on 8/2/22 at 2:34 p.m. The diagnoses included but were not limited to, dementia and hyperthyroidism. The vitals section of the clinical record indicated a weight of 150.4 pounds on 7/11/22 and a weight of 133 pounds on 8/4/22, an 11.6% loss. The 6/7/22 NP (Nurse Practitioner) note indicated she was seen for hyperthyroidism and had lost 23 pounds since December, 2021. The Assessment and Plan section indicated to Methimazole Tablet 10 mg daily and that she was refusing to take her oral medications. The July and August, 2022 MARs (medication administration records) indicated she refused the Methimazole 18 times between 7/1/22 and 8/4/22.	F 0657	The facility will ensure this requirement is met through the following corrective measures: 1. Resident #88's care plan was reviewed/revised. An order was obtained to give medications in ice cream or oatmeal. Resident # 67 and resident #26 have been scheduled for care plan meetings and invitations made. Resident #80's care plan was reviewed and revised to reflect current status. 2. All residents have the potential to be affected. Care plans have been reviewed and revised as indicated. Care plan meetings were identified previously in facility QAPI meeting and care plan meeting invitations are being sent as the resident's next OBRA assessment is completed. 3. The Care Planning policy was reviewed and no changes were indicated. The HFA or her designee will review 3 residents weekly to ensure there is documentation that care plan meeting invitations have been made//sent weekly for 6 weeks and until 100% compliance is achieved, then 5 residents per month for 6 months and until	09/07/2022

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	An interview was conducted with LPN (Licensed Practical Nurse) 7 on 8/8/22 at 4:00 p.m. She indicated she would put Resident 88's medication in ice cream or oatmeal and "she'll eat it all." She usually worked in the evenings, but Resident 88 often refused her medications during the day shift. She stated, "If they just put it in ice cream, she'd take it." She was unsure if there was an order to take her medication with ice cream or oatmeal, but was pretty sure she'd spoken with the nurse practitioner about it, and she was okay with it. The behavior, thyroid function, and nutrition care plans did not reference her refusal to take her medication or any interventions to address it. 2. The clinical record for Resident 67 was reviewed on 8/2/22 at 2:28 p.m. The diagnosis for Resident 67 included, but was not limited to, depressed mood. An interview was conducted with Resident 67 on 8/2/22 at 2:28 p.m. He indicated he had not had a care plan meeting. A care plan meeting for Resident 67 was conducted on 11/18/21. 3. The clinical record for Resident 26 was reviewed on 8/2/22 at 2:40 p.m. The diagnosis for Resident 26 included, but was not limited to, anxiety disorder. An interview was conducted with Resident 26 on 8/2/22 at 2:45 p.m. He indicated he had not been invited to a care plan meeting. He would like be attend if they have one.		100% compliance is maintained. The DON or her designee will audit 2 resident's plans of care weekly to ensure they are a current reflection of the resident's needs weekly for 6 weeks and until 100% compliance is achieved, then 5 a month for 6 months and until 100% compliance is maintained. 4. The findings of these reviews will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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A care plan meeting for Resident 26 was conducted on 12/4/20.

An interview was conducted with the Nurse Consultant on 8/3/22 at 10:46 a.m. She indicated she was unable to locate any current care plan meetings that had been held for Resident 26 and 67.

4. The clinical record for Resident 80 was reviewed on 8/5/22 at 1:53 p.m. Resident 80's diagnoses included, but not limited to, heart failure, cognitive communication deficit, diabetes type II, and muscle weakness. Resident 80 was admitted to the facility on 7/1/22.

Resident 80's admission MDS (minimum data set) dated 7/8/22 indicated, Resident 80 required extensive assistance of two persons for bed mobility and bathing; extensive assistance of one person for personal hygiene; and was totally dependent on the assistance of two persons for dressing and bathing.

An interview with PT (physical therapy) Director was conducted on 8/05/22 at 1:20 p.m. PT Director indicated, therapy services was asked to evaluate Resident 80 in the beginning of July 2022. Resident 80 received therapy services from her admission through 7/15/22. During Resident 80's time with therapy, the insurance company deemed she was not experiencing significant gains and therapy services were stopped. PT Director indicated, at the time therapy services were stopped, Resident 80 required extensive physical assistance with most activities of daily living, required a sling lift for transfers, and was not safe to discharge home.

Resident 80's care plan dated 7/12/22 indicated,

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she needed assistance with ADLs (activities of daily living) related to activity intolerance with a goal of to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, or bedpan at an independent level using her care plan interventions. Interventions included, but not limited to, position herself on the toilet and will be able to go to the bathroom independently. Resident 80's care plan did not include any further ADL needs nor did address her need for a sling lift or assistance with bed mobility, transfers, personal hygiene, dressing or bathing.

Resident 80's care plan dated 7/14/22 indicated, she had an indwelling Foley catheter (urinary catheter) with a goal to have it removed when medically indicated.

A physician's order dated 7/6/22 indicated, to remove Resident 80's Foley catheter.

An observation of Resident 80 made on 8/02/22 at 11:39 a.m. found she did not have an indwelling Foley catheter.

An interview with MDSC (minimum data set Coordinator) conducted on 8/05/22 at 2:22 p.m. indicated, Resident 80's care plan should have been updated to reflect her current needs and interventions. She further indicated, she care planned Resident 80 in regards for her future goals. The care plan did not reflect Resident 80's current needs and/or interventions in respect to activities of daily living. She further indicated, the care plan for the Foley catheter should have been removed from her care plan.

A care planning policy was provided by the

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	Executive Director on 8/5/22 at 2:22 p.m. It indicate "...Policy: It is the policy of this facility to develop a comprehensive plan of care that is individualized, and reflective of the resident's goals, preferences, and services that are to be provided to attain or maintain the resident's highest practical physical, mental and psychosocial well-being...Procedure:...2. The resident/resident representative will be invited to each care plan meeting to ensure they are fully aware, informed and participate in his/her health status/medical condition...13. The resident/resident representative will have the care plan reviewed with them: a. The facility will print a copy of the care plan and will go over the care plan with the resident/resident representative; the resident/resident representative will sign the care plan signature with the content. The signature page of the care plan will be scanned into the electronic medical record. b. If the resident/resident representative declines to participate in care planning or the care plan reviews, documentation will be placed in the resident medical record that the resident and resident representative was offered to participate and declines...14. The comprehensive care plan will be completed within 7 days after completion of the comprehensive MDS [Minimum Data Set assessment]...17. The comprehensive care plan will be reviewed and updated after each quarterly and comprehensive MDS assessment. " 3.1-35(d)(1)(2)(B) 3.1-35(d)(2)			
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			

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	nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure personal hygiene assistance was provided to a resident, who were dependent on staff for ADLs (activities of daily living) related to a female resident having chin/neck hair for 1 of 1 residents reviewed for ADLs. (Resident 80) Findings include: The clinical record for Resident 80 was reviewed on 8/5/22 at 1:53 p.m. Resident 80's diagnoses included, but not limited to, heart failure, cognitive communication deficit, diabetes type II, and muscle weakness. Resident 80 was admitted to the facility on 7/1/22. Resident 80's admission MDS (minimum data set) dated 7/8/22 indicated, Resident 80 required extensive assistance of two persons for bed mobility and bathing; extensive assistance of one person for personal hygiene; and was totally dependent on the assistance of two persons for dressing and bathing. An observation of Resident 80 was made on 8/05/22 at 2:05 p.m. Resident 80 had chin/neck hair. She indicated, staff had never offered to shave her chin/neck hair, but her niece had shaved it for her in the past when she had visited. An observation of Resident 80 was made on 8/08/22 at 10:47 a.m. Resident 80 still had chin/neck hair present. She indicated, she received a bath the previous day, but the staff member had not offered to shave her chin/neck hair for her. She indicated, she would not refuse for assistance with the chin/neck hair removal.	F 0677	The facility will ensure this requirement is met through the following corrective measures: 1. Residents #80 was provided with assistance with shaving as soon as the facility was notified of the concerns.2. All residents have the potential to be affected. Rounds completed to ensure residents who need assistance with shaving was provided. See below for corrective measures moving forward.3. The personal hygiene policy was reviewed. No revisions are indicated. Staff education initiated on this policy. A Performance improvement tool has been initiated. The DON/designee will check 10 random residents who require assistance with shaving/facial hair removal has been performed. Audits will continue weekly for 4 weeks and until 100% compliance is achieved, then 10 residents per month for 6 months and until 100% compliance is maintained. 4. The findings of these observations will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	09/07/2022

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	A Personal Hygiene policy was received on 8/8/22 at 11:01 a.m. The policy indicated, "1. Personal hygiene will be performed 2 times daily in the morning and before bed...4. Personal hygiene may include, but is not limited to: a. Oral Care b. Washing face and hands c. Washing axcillary[sic, armpits] area and perineum[sic, area between anus and scrotum in males and anus and vulva in females] area... g. Shaving..." 3.1-38(a)(3)			
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview, and record review, the facility failed to provide an ongoing activity program for 5 of 5 cognitively impaired residents on the 400 hall reviewed for activities. (Residents 3, 18, 33, 61, and 100) Findings include: 1. The clinical record for Resident 3 was reviewed on 8/8/22 at 10:02 a.m. The diagnoses included, but were not limited to, hypertension.	F 0679	1. No residents were harmed. The Activities Department continues to recruit/hire staff. The new Activities Director is registered to attend the next Activities Director course to be held in October. Lacy Beyl & Company, Inc. has been and continues to provide consultation, including completion of the Activities monthly calendar. More	09/07/2022

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	The 7/25/22 Quarterly MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status score) of 5, indicating she was severely cognitively impaired. The 5/20/22 activity care plan indicated she needed assistance to and from activities and would benefit from invites and 1:1 visits with staff. The July and August, 2022 activity logs were provided by the AIT (Administrator in Training) on 8/8/22 at 2:42 p.m. They did not indicate any activity attendance or participation. An observation was made on 8/5/22 at 10:55 a.m. She was sitting in her wheel chair in the lounge area of the 400 hall. She was facing the television, with her head down and eyes closed. There were no activities occurring on the unit. An observation was made on 8/8/22 at 11:04 a.m. in thee lounge area of the 400 hall. She was sitting in her wheel chair in front of the television. Her eyes were closed and she was not watching television. An observation was made on 8/9/22 at 11:54 a.m. She was sitting in her wheel chair in the lounge area of the 400 hall in front of the television. Her head was down and her eyes were closed. There were no activities occurring on the unit. An observation was made on 8/9/22 at 1:32 p.m. She was sitting in her wheel chair in the lounge area of the 400 hall in front of the television. Her head was down and she was not watching television. 2. The clinical record for Resident 18 was		activities for cognitively impaired residents will be added and residents encouraged/assisted to those activities, to include residents #3, 18, 33, 61, and 100. 2. All residents have the potential to be affected. Lacy Beyl & Company, Inc. has been and continues to provide consultation, including completion of the Activities monthly calendar. More activities for cognitively impaired residents will be added and residents encouraged/assisted to those activities. 3. The Activities Program policy was reviewed and no changes were indicated. Activities staff were educated on this policy. The HFA or her designee will monitor activity attendance for 5 cognitively impaired residents weekly to ensure they are involved in activities as preferred for 6 weeks and until 100% compliance is achieved, then 10 residents per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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reviewed on 8/2/22 at 12:20 p.m. The diagnoses included, but were not limited to, heart failure, anxiety, and depression.

The 5/26/22 Quarterly MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status score) of 7, indicating she was severely cognitively impaired.

The 4/13/22 activity care plan, revised 12/6/21, indicated she would benefit from invites and reminders to attend activities of her choice. She enjoyed bingo, pokeno games, and religious programs.

The July and August, 2022 activity logs were provided by the AIT (Administrator in Training) on 8/8/22 at 2:42 p.m. The did not indicate any activity attendance or participation.

An interview was conducted with Resident 18 on 8/2/22 at 12:29 p.m. She was sitting in her wheel chair in her room. She indicated the facility did not have any activities, and if they did, she'd never been to any. She loved bingo, but they didn't have it.

3. The clinical record for Resident 33 was reviewed on 8/8/22 at 10:50 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, depression, and psychotic disorder.

The 6/3/22 Quarterly MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status score) of 7, indicating she was severely cognitively impaired.

The 10/19/20 activity care plan, revised 7/27/22, indicated she benefited from personal invites to scheduled activities and needed assistance and

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verbal cueing at times. She enjoyed listening to old school music and enjoyed doing crafts. The staff would encourage her to take an active role and deciding activities to participate in such as nails, bingo, cooking club, visits, bible study, special entertainment, and games.

The July and August, 2022 activity logs were provided by the AIT (Administrator in Training) on 8/8/22 at 2:42 p.m. The did not indicate any activity attendance or participation.

An observation was made on 8/8 at 11:04 a.m. in the lounge area of the 400 hall. The television was on, but she was not watching it, and her eyes were closed.

4. The clinical record for Resident 61 was reviewed on 8/2/22 at 3:00 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, depression, and psychotic disorder.

The 6/21/22 Quarterly MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status score) of 00, indicating she was severely cognitively impaired.

The 2/21/20 activity care plan, revised 9/20/21, indicated she enjoyed live entertainment and happy hour, live music performers, and small appropriate sensory groups.

The July and August, 2022 activity logs were provided by the AIT (Administrator in Training) on 8/8/22 at 2:42 p.m. They did not indicate any activity attendance or participation.

An observation was made on 8/2/22 at 3:17 p.m. She was sitting in her wheel chair in the lounge area of the 400 hall. The television was on, but she

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CREEKSIDE HEALTH AND REHABILITATION CENTER	3114 EAST 46TH STREET INDIANAPOLIS, IN 46205

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was not watching it. There were 5 other residents present in the area and only one of them was looking at the television. There were no activities occurring on the unit.

An observation was made on 8/5/22 at 10:55 a.m. She was sitting in her wheel chair in her room. Her head was down and eyes were closed. There were no activities occurring on the unit.

An observation was made on 8/8/22 at 11:04 a.m. in the lounge area of the 400 hall. The television was on, but Resident 61 was not watching, and her eyes were closed.

5. The clinical record for Resident 100 was reviewed on 8/8/22 at 10:00 a.m. The diagnoses included, but were not limited to, dementia.

The 7/13/22 Quarterly MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status score) of 2, indicating she was severely cognitively impaired.

The 12/14/19 activity care plan, revised 4/27/22, indicated she would benefit from person encouragement and reminders to activities. During groups she would benefit from simple directions, repeats and assistance as needed. Encourage her to actively participate in the activities of her choosing like bingo and watching western movies She would attend 2 or 3 group activities of her choice including crafts, sensory programs, and exercises.

The July and August, 2022 activity logs were provided by the AIT (Administrator in Training) on 8/8/22 at 2:42 p.m. They did not indicate any activity attendance or participation.

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An observation was made on 8/5/22 at 10:55 a.m. in the lounge area of the 400 hall. She was sitting in her wheel chair. The television was son, but her back was to the television and her eyes were closed.

An observation was made on 8/8/22 at 11:04 a.m. in the lounge area of the 400 hall. The television was on, but her eyes were closed and she was not watching.

An interview was conducted with LPN (Licensed Practical Nurse) 8 on 8/5/22 at 10:57 a.m. She indicated Resident 61 "just wants something to do." She would travel off the unit in her wheel chair and someone from another unit would bring her back. Resident 61's children informed her she used to be a secretary and in the military, so they would let her pretend to type on the keyboard sometimes. There could be more activities on the unit. They used to regularly have activities on the other end of the dining room, but there were no group activities on the unit now. They used to have trivia, Bible study, and nails, but when activity staff started leaving the department, the activity staff stopped coming to the unit. There used to be an activity person for each unit and large group activities like bingo or happy hour in the main activity room. Sometimes she would sing for residents and they would clap and participate. Residents, like Resident 3, Resident 33, and Resident 100
liked being out of their rooms and in the lounge area. Residents 3, 18, 33, 61, and 100 would all participate in Bible study if they had it. Residents 61 and 18 would both participate in trivia or nail care, if it was happening. No activities like that had occurred on the unit in the past 3 weeks. She'd noticed, since the decline in activities, the residents had been wanting to leave the dining

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room more when waiting for meals to be served, wanting to move around and do something. On those days, staff was constantly redirecting them, asking them to sit down and please not leave the dining room before the meal was served. If they were engaged in an activity, they wouldn't be trying to leave the dining room, and it would be more conducive for nursing staff not having to redirect so often. She stated, "I think they're bored."

An interview was conducted with LPN 8 on 8/8/22 at 11:27 a.m. She indicated Residents 3, 18, 33, 61, and 100 weren't likely to go to another hall for activities, stay, and participate. They needed to figure out how to have activities on their hall. They used to have movies, nail care, Bible study, arts and crafts. She hadn't seen anything like that going on in the 3 weeks she'd been back at the facility working 3 days a week on day shift. Residents 3, 18, 33, 61, and 100 "could use more activities," because it would be something for them to do. She and the other nursing staff were busy, providing care and they didn't really have the time to do activities with residents. Having someone specific coming to the unit for activities would really help and prevent nursing from having to make sure where residents were at all times. A CNA could do activities, but there would need to be an extra CNA on the unit for that. They had several residents on the unit who required extensive care.

An interview was conducted with CNA 20 on 8/8/22 at 11:36 a.m. She indicated she'd been working at the facility since the beginning of July, 2022. She did not have time to do group activities on the 400 hall. They would need an extra CNA for that, as the 400 hall was a busy unit. Residents required more checks and changes, lifts for

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transfers, and assistance with feeding.

An interview was conducted with the Interim AD (Activity Director) on 8/8/22 at 12:08 p.m. He indicated he just started in the position on 8/2/22. He was an Administrator in Training and had never been an AD prior to last week. He'd participated in activities on Memory Care Units before, but never created an activity program for one. Music trivia, crafts, coloring, and hands on activities would be good for cognitively impaired residents. Since he'd been at the facility, most of the activities occurred on the 100 hall.

An interview was conducted with AA (Activity Assistants) 17 and 18 on 8/8/22 at 1:45 p.m. in activity room. AA 17 indicated she'd worked at the facility since January, 2022. They hadn't done very many activities specific to cognitively impaired residents or on the 400 hall. They hadn't had an AD (Activity Director) since June, 2022. The current AD just came last week, and there were only 2 activity assistants, including her. They spent more time on the 200 hall with the more cognitively intact residents, because they "really want to do activities," but the residents on the 400 hall needed stimulation. "We just cant be 2 places at once." They needed at least 2 more staff in thee activity department. If they had 2 more, they could split up and someone could go to the 400 hall, so there could be ongoing activities.

The Activities Program policy was provided by the AIT on 8/8/22 at 2:42 p.m. It read, "It is the policy of this facility to provide, based on the comprehensive assessment, care plan, and preferences for each resident, an ongoing program that supports each resident in their choice of activities, both facility-sponsored group and

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	independent activities designed to meet the interests and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community....Responsibilities: ...Assuring residents requiring one to one intervention receive timely and appropriate activity programs. Providing individualized and modified programs to residents with special needs. Resident's with special needs may be, but are not limited to cognitively impaired, hearing impaired, intellectual/developmental disability, or whose diagnosis inhibits them from participating in traditional activities programs....Recording the attendance of residents at all activities, including independent leisure pursuits based on their preferences and interests. 3.1-33(a)			
F 0680 SS=C Bldg. 00	483.24(c)(2)(i)(ii)(A)-(D) Qualifications of Activity Professional §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			

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	by the State. Based on observation, interview, and record review, the facility failed to ensure the activities program was directed by a qualified professional for 103 of 103 residents in the facility. Findings include: The Employee Records form was provided by the ED (Executive Director) on 8/5/22 at 8:37 a.m. They indicated the Interim AD (Activity Director) began working at the facility on 2/14/22. An interview was conducted with the Interim AD on 8/8/22 at 12:08 p.m. He indicated he just started in the position on 8/2/22. He was an Administrator in Training and had never been an AD prior to last week. Someone else was filling in prior, but was unsure whom. He'd participated in activities, but never had to create an activity program. He received a Bachelor's Degree in marketing and management in 2019. He had not completed a state approved activities training course. He had participated in community activities at a previous job, but did not have one year of full time experience in activities. An interview was conducted with AA (Activity Assistants) 17 on 8/8/22 at 1:45 p.m. in activity room. AA 17 indicated she'd worked at the facility since January, 2022. They hadn't had an AD (Activity Director) since June, 2022. The current AD just came last week, and there were only 2 activity assistants, including her. They needed at least 2 more staff in the activity department. If they had 2 more, they could split up and someone could go to the 400 hall, so there could be ongoing activities. The ED provided the Position History for the AD	F 0680	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. 2. All residents have the potential to be affected. See below for corrective measures. 3. The Activities Program policy was reviewed and no changes were indicated. An Activity Director has been obtained and she is registered to attend the Director's course in the next available class in October. Until then, Lacy Beal & Consultants will continue to provide at least monthly consultation for the Activities Department. Lacy Beal's report will be reviewed monthly by the HFA and recommendations executed to ensure continued compliance for 6 months and until 100% compliance is achieved and maintained. 4. The findings of these reviews will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	09/07/2022

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	prior to the current Interim AD. It indicated she was employed at the facility from 11/1/21 through 6/15/22. The Activities Program policy was provided by the AIT (Administrator in Training) on 8/8/22 at 2:42 p.m. It read, "The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional that has the following qualifications: Is a licensed or registered, if applicable, by the state in which practicing; and Is 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 Has two 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 Is qualified occupational therapist or occupational therapy assistant; or Has completed a training course approved by the State." This Federal Tag relates to complaint IN00386617. 3.1-33(e)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to notify the medical provider of abnormal	F 0684	The facility will ensure this requirement is met through the	09/07/2022

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	blood pressure readings, administer medications as ordered, and a wound treatment as ordered for 2 of 5 residents reviewed for unnecessary medications and 1 of 1 resident reviewed for accidents (Resident 5, 20 and 57) Findings include: 1. The clinical record for Resident 5 was reviewed on 8/3/22 at 2:26 p.m. The diagnoses for Resident 5 included, but were not limited to, type 2 diabetes mellitus and anxiety. A care plan dated 6/8/22 indicated "I am at risk for my blood sugars to fluctuate related to hypoglycemia.. A physician order dated 7/26/21 indicated staff was to obtain blood sugars from Resident 5 before meals and at night. A physician order dated 9/8/21 indicated Resident 5 was to receive 15 units of humalog insulin 3 times a day. The staff was not to administer if the residents blood sugar was less than 150. A physician order dated 7/27/21 indicated resident was to receive a sliding scale of humalog insulin 3 times a day. The sliding scale was the following: 251-300 = 2 units, 301-350 = 4 units, 351-400 = 6 units. A physician order dated 9/8/21 indicated staff was to administer 36 units of glargine insulin at bedtime. A physician order dated 7/27/21 indicated the resident was to receive 5 milligrams of glipzide daily.		following corrective measures: 1. No harm incurred to resident #5, 20, 57. 2. All other resident have the potential to be affected. See below for corrective measures moving forward. 3. The medication/treatment administration policy and Following Medication/Physician Orders policy was reviewed and no changes were indicated. Licensed nurses and QMA's educated on the medication/treatment administration policy and Following Medication/Physician Orders policy. A performance improvement tool has been initiated. The DON/Designee will complete a random audit of EMARs/ETARs to ensure medications are administered per order, call/hold parameters are followed , MD notification is made when indicated, and treatments are completed as prescribed for 10 residents per week for 4 weeks until 100% compliance is achieved ,then 10 residents bi weekly x4 weeks, then 10 residents per month for 4 months until 100% compliance is maintained. 4. The findings of these reviews will be presented to the QAPI committee during the facilities monthly meetings and the plan of	

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	The July 2022 and August 2022 Medication Administration Record indicated the following days, shifts, and blood sugar readings, the staff had administer the 15 units of humalog not as ordered: 7/3/22 1:00 p.m. - blood sugar 149, 7/9/22 1:00 p.m. - blood sugar 141, 7/10/22 1:00 p.m. - blood sugar 126, 7/11/22 4:00 p.m. - blood sugar 147, 7/14/22 - 9:00 a.m. - blood sugar 144, 4:00 p.m. - blood sugar 152, 7/15/22 - 9:00 a.m. - blood sugar 117, 7/16/22 - 9:00 a.m. - blood sugar 117, 1:00 p.m. - blood sugar 154, 7/17/22 - 9:00 a.m. - blood sugar 120, 1:00 p.m. - blood sugar 114, 7/19/22 - 9:00 a.m. - blood sugar 140, 4:00 p.m. - blood sugar 103, 7/20/22 - 1:00 p.m. - blood sugar - 124, 4:00 p.m. - blood sugar 124, 7/21/22 - 9:00 a.m. - blood sugar 110, 1:00 p.m. - blood sugar 114, 7/22/22 - 9:00 a.m. - blood sugar 119, 4:00 p.m. - blood sugar 124, 7/23/22 - 9:00 a.m. - blood sugar 147, 1:00 p.m. - blood sugar 147, 7/24/22 - 9:00 a.m. - blood sugar 142, 7/25/22 - 9:00 a.m. - blood sugar 138, 4:00 p.m. - blood sugar 143, 7/27/22 - 4:00 p.m. - blood sugar 142, 7/28/22 - 9:00 a.m. - blood sugar 129, 7/31/22 - 9:00 a.m. - blood sugar 127, 1:00 p.m. - blood sugar 154, 8/1/22 - 4:00 p.m. - blood sugar 133, and 8/2/22 - 9:00 a.m. - blood sugar 135 An interview was conducted with the Director of Nursing and the Nurse Consultant on 8/9/22 at		action adjusted accordingly	

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3:28 p.m. The Nurse Consultant indicated the staff should not be administering the 15 units of humalog if the resident's blood sugar is less than 150.

2. The clinical record for Resident 20 was reviewed on 8/9/22 at 8:52 a.m. The diagnosis for Resident 20 included, but was not limited to, type 2 diabetes mellitus.

A care plan last review date of 6/2/22 indicated "I am at risk for my blood sugars to fluctuate related to DX [diagnosis] DM 2 [diabetes mellitus type 2]. I tend to get upset with nursing staff when I refuse a meal and they do not administer my insulin because my blood sugar is low. Interventions...Check my blood sugars as ordered.."

A care plan last review date of 6/2/22 indicated "I have essential hypertension of unknown origin. Interventions...I will take my antihypertensive medication(s) as ordered..."

A physician order dated 5/11/22 indicated staff was to give 12.5 milligrams of carvedilol tablets twice a day. The order indicated "call MD [medical doctor] if systolic blood pressure was [symbol for greater than] 160 or diastolic blood pressure was [symbol for greater than] 100."

The July 2022 Medication Administration Record (MAR) indicated the following days, shifts and blood pressures that were not within the parameter, and the medical provider was not notified as ordered:

7/14/22 - 9:00 a.m. - 173/78,
7/15/22 - 9:00 a.m. - 171/91,
7/17/22 - 7:00 p.m. - 170/78,

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7/21/22 - 9:00 a.m. - 171/77,
7/23/22 - 9:00 a.m. - 169/72, and 7:00 p.m. - 169/72,
7/24/22 - 9:00 a.m. - 169/72, and 7:00 p.m. - 169/72,
7/28/22 - 7:00 p.m. - 162/81 and
7/29/22 - 9:00 a.m. - 163/87

The August 2022 Medication Administration Record (MAR) indicated the following days, shifts and blood pressures that were not within the parameter, and the medical provider was not notified as ordered: 8/3/22 - 7:00 p.m. - 168/68 and 8/9/22 - 9:00 a.m. - 163/76

An interview was conducted with the Director of Nursing on 8/9/22 at 11:03 a.m. She indicated she was unable to locate any notes in Resident 20's clinical record the medical provider was notified the resident's systolic blood pressure was greater than 160.
3. The clinical record for Resident 57 was reviewed on 8/2/22 at 12:11 p.m. The Resident's diagnosis included, but were not limited to, diabetes and anxiety.

A Quarterly MDS (Minimum Data Set) Assessment, completed on 6/17/22, indicated he was cognitively intact and was able to make self-understood and to understand what was being said to him.

A physician's progress note, dated 7/14/22, indicated he was being seen for a right toe wound. He is concerned about a possible infection of the right toe. The physical exam showed the right great toe had redness, warmth, and an open wound. The assessment and Plan was that he had an infected abrasion of right great toe and was to receive Keflex (antibiotic) twice daily for 5 days to treat the infection.

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	A physician's order, dated 7/14/22, indicated he was to be given Keflex 500mg (milligram) two times a day every 5 days for toe wound infection. The July 2022 MAR (Medication Administration Record) indicated he had received the Keflex on the evening shift of 7/14/22, the day and evening shift of 7/19/22, and the day and evening shift of 7/24/22. A physician's order dated 7/23/22, indicated he was to receive Betadine (antiseptic solution) to his right great toe. It was to be covered with an ABD pad (type of dressing) and secured with kerlix (wrap dressing) and tape. It was to be changed each night shift. During an interview on 8/2/22 at 12:13 p.m., Resident 57 indicated he had no feeling in his right foot. His left leg had been amputated recently due to a non-healing wound and that he now had a wound on his right great toe. The treatment to the wound did not always get completed timely. During an interview on 8/4/22 at 1:45 p.m., the NC (Nurse Consultant) indicated the physician's order for Keflex had been transcribed incorrectly into the electronic medical record and should have been administered as ordered by the physician. A nursing progress note, dated 8/7/22 at 2:59 p.m., read "resident did not get scheduled treatment to his foot on midnight shift, this nurse was unable to get to treatment today." The August TAR (Treatment Administration Record) indicated the treatment to his right great toe was not signed off as completed on 8/6/22 and 8/7/22.			

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	During an interview on 8/8/22 at 4:25 p.m., Resident 57 indicated his dressing on his right toe did not get changed on 8/6/22 or 8/7/22. During an interview on 8/9/22 at 4:10 p.m., the NC indicated the treatment to his right great toe should have been completed as ordered by the physician. 3.1-37			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.			
	Based on interview and record review, the facility failed to ensure a hearing consultation was arranged for a resident with hearing loss for 1 of 3 residents reviewed for vision and hearing. (Resident 37) Findings include: The clinical record for Resident 37 was reviewed on 8/3/22 at 10:28 a.m. The diagnoses for Resident 37 included, but was not limited to, stage 4 chronic kidney disease and receptive-expressive	F 0685	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 37 will be seen by the audiologist on the next visit which is 10/21/22. 2. A review of all residents has been completed to ensure if audiology services are needed that a referral has been made and he/she is added to the list to be seen.	09/07/2022

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	language disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 6/13/22, indicated Resident 37 was cognitively impaired. A medical provider comprehensive review of chronic conditions note dated 7/8/22 indicated Resident 37 had hearing loss. The plan indicated "Consult audiology for hearing aid consultation." An interview was conducted with Family Member 14 on 8/3/22 at 10:51 a.m. She indicated the resident had hearing loss and needed hearing aides replaced. He had some prior to admission to facility. An ear doctor had been in approximately a month ago and cleaned his ears. She had stated she would have him looked at to get new hearing aides. Family Member 14 had not heard anything about the consult since that day. The ancillary report was provided by the Executive Director on 8/4/22 at 11:15 a.m. It indicated audiology had been in the facility on 8/2/22. An interview was conducted with the Social Services Director on 8/5/22 at 2:34 p.m. She indicated the medical provider group usually sends her emails when ancillary services are needed. She had not received an email that indicating Resident 37 needed to be seen by audiology. A hearing services policy was provided by the Executive Director on 8/8/22 at 10:27 a.m. It indicated "...Policy. It is the policy of this facility to assure all resident's with...hearing...needs are seen by the consultation in these areas...4. The Social Service Director or Designee shall be		3. The Dental, Hearing, Vision policy was reviewed and no changes indicated. Social services staff will be educated on this policy. The Social Services Director or her designee will audit twice monthly to ensure that those residents with hearing concerns/needs have been referred to audiology services and added to the visit list. These audits will continue twice monthly for six months and until 100% compliance is achieved, then monthly for 6 months and until 100% compliance is maintained. 4.The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	responsible for coordinating the ancillary service provider's visit as necessary. Nursing and Social Services will communicate to ensure all residents needing to be seen are on the list..." 3.1-39(a)			
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 ensure the placement of prevalon boots as ordered for 1 of 1 residents reviewed for pressure. (Resident 47) Findings include: The clinical record for Resident 47 was reviewed on 8/2/22 at 3:00 p.m. The diagnosis for Resident 47 included, but was not limited to, cerebral palsy. A physician order dated 3/24/20 indicated Resident 47 was to wear prevalon boots (pressure relief boots) at all times for preventative measures.	F 0686	The facility will ensure this requirement is met through the following corrective measures: 1. No harm was incurred to (Resident # 47) by the alleged deficient practice. 2. All residents requiring pressure reducing/relieving devices to promote healing and prevention of pressure ulcers have the potential to be affected. See below for corrective measures moving forward.	09/07/2022

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	Observations were made of Resident 47 on 8/2/22 at 3:04 p.m., and 8/3/22 at 10:54 a.m. The resident was not observed with prevalon boots on his feet. An observation was made of Resident 47 with Certified Nursing Assistant (CNA) 6 on 8/3/22 at 3:35 p.m. The resident was not observed wearing prevalon boots on his feet. An interview was conducted with License Practical Nurse (LPN) 7 on 8/3/22 at 3:45 p.m. She indicated Resident 47 does not wear prevalon boots on his feet. After reviewing of his orders, she indicated the resident did have an order to wear the prevalon boots at all times. She would find him some. 3.1-40(2)		3. Audit completed for residents with pressure reducing/relieving devices to ensure devices are in place per plan of care. Staff educated on the importance the positing devices. A Performance improvement tool has been initiated. The DON/designee will check 10 random residents with pressure reducing/relieving devices to ensure devices are in place per plan of care. Audits will continue 3x week for 4 weeks, weekly x 4 weeks, then 10 residents per month for 4 months until 100% compliance is maintained. 4. The findings of these reviews will be presented to the QAPI Committee during the facility's monthly meetings and the plan of action adjusted accordingly.	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.			

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	§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to ensure the placement of a resident's hand splint and carrot splint (a device placed in contracted hand) in his palm per the plan of care for 1 of 1 residents reviewed for limited range of motion (ROM). (Resident 47) Findings include: The clinical record for Resident 47 was reviewed on 8/2/22 at 3:00 p.m. The diagnosis for Resident 47 included, but was not limited to, cerebral palsy. An Occupational Therapy plan of treatment dated 10/20/20 indicated "...Pt referred to skilled occupational therapy to assess pt's new L (left) resting hand splint and educate caregivers on wear schedule....Assessment Summary...Clinical Impressions:..PT to wear L resting hand splint for up to 8 hours/day with monitoring for signs/symptoms of pain or skin irritation and any change of ROM..." A care plan for activities of daily living (ADLS) assistance for Resident 47 dated 10/15/21, indicated "...Pt [patient] tolerate up to 8 hours of left resting hand splint to maintain ROM and skin integrity...Slide blue carrot into right hand, small end will between thumb and palm..." Observations were made of Resident 47 on 8/2/22 at 3:04 p.m., and 8/3/22 at 10:54 a.m. The resident was not observed with a left hand splint nor a	F 0688	The facility will ensure this requirement is met through the following corrective measures: 1. No harm was incurred to (Resident # 47) by the alleged deficient practice. 2. All other residents requiring assistance with limited range of motion/mobility have the potential to be affected. See below for corrective measures moving forward. 3. Audit completed for residents who have splits ordered per plan of care. Staff education initiated on the importance applying range of motion devices. A Performance improvement tool has been initiated. The DON/designee will check 10 random residents with orders for a split to ensure devices are in place per plan of care on varying days and shifts. Audits will continue 3 times a week for 4 weeks, weekly x 4 weeks then 10 residents per month for 4 months until 100% compliance is maintained. 4. The findings of these reviews will be presented to the	09/07/2022

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	carrot splint in right hand. An observation was made of Resident 47 with Certified Nursing Assistant (CNA) 6 on 8/3/22 at 3:35 p.m. The resident was not observed with a hand splint on his left hand nor a carrot split in his right hand. An interview was conducted with License Practical Nurse (LPN) 7 on 8/3/22 at 3:45 p.m. She indicated Resident 47 does not wear any splints in his right or left hands. An interview was conducted with the Therapy Director on 8/5/22 at 1:57 p.m. She indicated she did not see any recommendations by therapy to wear a carrot splint in his right hand, but he was to wear the left hand splint up to 8 hours a day. An interview was conducted with the Nurse Consultant on 8/8/22 at 3:10 p.m. She indicated the staff should be following the resident's plan of care. A care planning policy was provided by the Executive Director on 8/5/22 at 2:22 p.m. It indicated, "...Policy: It is the policy of this facility to develop a comprehensive plan of care that is individualized, and reflective of the resident's goals, preferences, and services that are to be provided to attain or maintain the resident's highest practical physical, mental and psychosocial well-being..." 3.1-42(a)(2)		QAPI Committee during the facility's monthly meetings and the plan of action adjusted accordingly.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy			

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	tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on observation, interview, and record review, the facility failed to follow through with a dietician requested reweigh for 1 of 4 residents reviewed for nutrition. (Resident 106) Findings include: The clinical record for Resident 106 was reviewed on 8/8/22 at 2:00 p.m. The diagnoses included, but were not limited to, Alzheimer's disease. The nutrition care plan, revised 3/22/22, indicated an intervention was to review her weight. The Weights and Vitals Summary of the clinical record indicated a weight of 170.1 pounds on 6/7/22 and a weight of 147 pounds on 7/1/22, a 13.6% loss. The 7/19/22 dietary note, written by the RD	F 0692	The facility will ensure this requirement is met through the following corrective measures: 1. Resident # 106's medical recorded was reweighed and the medical record was updated. 2. All residents have the potential to be affected. See below for corrective measures. 3. Staff were educated on the weight policy. The DON or her designee will audit to ensure adequate weights have been obtained and entered into the medical record timely. 3. The weight policy was reviewed.	09/07/2022

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	(Registered Dietician,) read, "July reweight requested." There were no reweights in the clinical record after the 7/1/22 weight of 147 pounds. An interview and observation was conducted with LPN (Licensed Practical Nurse) 8 on 8/8/22 at 2:31 p.m. at the nurse's desk. She indicated CNAs (Certified Nursing Assistants) usually do reweighs. She reviewed Resident 106's weights in the clinical record and indicated she thought the 147 pound weight on 7/1/22 was wrong, and she would reweigh her. LPN 8 left the nurse's desk to assist QMA (Qualified Medication Aide) 19 with weighing Resident 106, who was in her wheel chair, on the scale located near the nurse's desk. LPN 8 announced a weight of 191. 6 pounds. The tag on Resident 106's wheel chair read 46 pounds. LPN 8 indicated Resident 106's weight was 145.6 pounds, but was going to have the wheel chair weighed again. An interview was conducted with UM (Unit Manager) 2 on 8/8/22 at 3:23 p.m. She indicated she weighed Resident 106 on 7/20/22 at 162.1 pounds, and documented another July, 2022 weight for 155.4 pounds. She should have documented the 2 additional July, 2022 weights in Resident 106's clinical record, but didn't. Resident 106 was reviewed in NAR (Nutrition at Risk) meetings. The last NAR meeting was 7/29/22, but she was unable to attend. UM 2 provided 2 Shift Report Sheets on 8/8/22 at 3:23 p.m. One had a handwritten weight of 162.1 with a handwritten date of 7/20/21. The other had a handwritten weight of 155.4 with a date of "July 2022."		No revisions are indicated. Staff were educated on the weight policy. A performance improvement tool has been initiated. The DON/designee will check 10 random resident weights/reweights to ensure accuracy weekly x 4 weeks, until 100% compliance is achieved, then 10 residents per month for 5 months and until 100% compliance is maintained. 4. The findings of these audits will be reviewed during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	An interview was conducted with the Registered Dietician on 8/8/22 at 3:30 p.m. She indicated she never received the requested reweigh for Resident 106. Resident 106 was reviewed in NAR meetings, but she didn't have an updated weight for her. The last NAR meeting was 8/4/22, where both she and UM 2 were present. They discussed Resident 106's intakes, supplements, and skin. UM 2 was going to ask the staff to get a reweight, but she hadn't yet heard back. The last weight she had for Resident 106 was 147 pounds on 7/1/22. She had nothing in her notes about any additional July, 2022 weights. 3.1-46(a)(1)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			
	Based on interview and record review, the facility failed to ensure assessments were conducted for a resident with a fistula for dialysis and pre and post assessments on dialysis day and to ensure a physician's order for a fistulagram was made timely for 2 of 2 residents reviewed for dialysis. (Resident 37 and 73) Findings include: 1. The clinical record for Resident 37 was reviewed on 8/3/22 at 10:28 a.m. The diagnosis for Resident 37 included, but was not limited to, stage 4 chronic kidney disease.	F 0698	The facility will ensure this requirement is met through the following corrective measures: 1. Resident #37 and #73 were not harmed. 2. All residents receiving dialysis services have the potential to be affected. See below for corrective measures. 3. The dialysis policy was reviewed and no changes were indicated. Staff were educated on	09/07/2022

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	A Quarterly Minimum Data Set (MDS) assessment, dated 6/13/22, indicated Resident 37 was cognitively impaired. A care plan dated 3/24/22 indicated "I [Resident 37] a fistula in my Lt [left] arm for possible dialysis. Interventions...Check the bruit and thrill [blood flow through a fistula] q [every] shift..." A nursing note dated 7/26/22 indicated the resident was to receive dialysis services starting on 7/29/22 at 4:30 p.m. An interview was conducted with Family Member 14 on 8/3/22 at 10:35 a.m. She indicated Resident 37 had started dialysis on 7/29/22. He was scheduled to go on Mondays, Wednesdays and Fridays. The resident's clinical record did not indicate assessments were conducted every shift of his thrill and bruit in June 2022 and July 2022 nor a pre and post assessment on 7/29/22. During an interview, conducted on 8/5/22 at 3:35 p.m., the Nurse Consultant indicated she was unable to locate assessments conducted for Resident 37's fistula nor a pre and post assessment on 7/29/22. She indicated the staff was to follow the plan of care, and should have been conducting the assessments for his fistula every shift and before and after assessments on dialysis days. 2. An interview with Resident 73 was conducted on 8/03/22 at 10:11 a.m. She indicated, she had been to the hospital three times recently related to right arm swelling. She stated the fistula in her right upper arm had "not been working" and she needed to have a fistulagram, but it hadn't been		the Dialysis policy. An audit completed to ensure residents who receive dialysis have an order in place to check the bruit and thrill each shift. The DON or her designee will complete an audit tool for all residents who receive dialysis 5x week x 4 weeks until 100% compliance is achieved, then 3x week x 4 weeks until 100% compliance is achieved , then weekly x 4 weeks until 100% compliance is achieved, then monthly for 3 months to ensure compliance is maintained. 4. The findings of these audits will be reviewed during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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scheduled yet. She indicated, the facility keeps saying "They are working on it". She stated, the swelling had been going on for three weeks. An observation made at the same time as the interview with Resident 73, found her right arm was noticeably swollen from her upper arm down to her hand and fingers.

The clinical record for Resident 73 was reviewed on 8/4/22 at 1:06 p.m. Resident 73's diagnoses included, but not limited to, heart failure, diabetes type II, end-stage renal disease, and dependence on renal dialysis.

A nursing note dated 7/13/2022 at 4:35 p.m. indicated, the results from a right upper extremity venous Doppler were negative for a blood clot.

A nursing note dated 7/19/2022 at 7:30 a.m. indicated, an order was received for venous Doppler to be performed related to increased swelling to the resident's right upper extremity.

A nursing note dated 7/24/2022 at 2:35 p.m., indicated, Resident 73's right arm was noted to be swollen, the physician had been made aware and Resident 73 denied pain at that time.

A nursing note dated 7/24/2022 at 7:13 a.m. indicated, Resident 73 had returned to the facility after midnight from the hospital related to swelling in right upper extremity. The nursing note stated, " Resident has lymphedema to right arm,[sic] writer elevated arm on pillow. N.N.O[sic, no new orders] per discharge paper work.[sic] follow up with nephrologist regarding fistula per instructions."

A nursing note dated 7/25/2022 at 2:55 p.m. indicated, an order was placed from Resident 73's

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nephrologist to send the resident to the hospital for evaluation and treatment for noted swelling to her right upper arm.

The discharge summary from the local hospital dated 7/25/22 indicated, to follow up with the specialist in 3-5 days and stated, "IR [sic, Interventional Radiology] will call to schedule Fistulagram[sic, a procedure to look at the blood flow in a fistula].

A nursing note dated 7/30/2022 at 3:34 p.m., indicated, Resident 73's arm still very swollen.

A nursing note dated 8/2/2022 at 7:02 p.m. indicated, the dialysis nurse called the facility and "voiced dialysis clinic is in the process of getting an appointment for patient's right arm/dialysis site to be evaluated and they will contact facility with appointment time when applicable".

An interview with Resident 73's dialysis center's charge nurse (DRN 1) was conducted on 8/04/22 at 1:23 p.m. DRN 1 indicated, Resident 73 is a new patient to them at the center as her previous center closed as of the end of July 2022. She indicated, they had noticed Resident 73's right arm was very swollen which is where she had her dialysis fistula. They were concerned and had called the previous dialysis center to get more information. The previous center had told them, Resident 73's swollen arm was not a new finding. Regardless of that information, the new dialysis center had sent out a request for Resident 73 to have a fistulagram. The fistulagram referral was sent out on 8/2/22, but as of present, had not been scheduled.

An interview with UM (Unit Manager) 2 was conducted on 8/4/22 at 2:57 p.m. UM 2 indicated,

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	when a resident had returned from the hospital, it is treated similar to a new admission where the discharge summary was reviewed, any new orders are reviewed with physician and then placed in their system. All new orders are reviewed again the next by the next shifts nurse, and lastly reviewed also by the nursing managers to ensure all orders have been addressed. She indicated, the hospital's discharge instruction for the Interventional radiology to schedule a fistulagram should have been follow up on within the same week as the hospital discharge. A dialysis policy was provided by the Executive Director on 8/5/22 at 2:22 p.m. It indicated, "...Purpose: Residents receiving hemodialysis will receive appropriate monitoring and care from the facility and the dialysis provider in order to coordinate care. To set appropriate guidelines for monitoring the health and safety of residents receiving dialysis care...Assessment: Monitoring of the dialsis fistula will be completed by the nurse assigned to the resident...Document the presence or absence of the bruit and thrill on the treatment record each shift...Pre and Post Dialysis: 1. A TLC pre-dialysis assessment will be completed before dialysis....2. A TLC post dialysis form will be completed after dialysis and compared to the pre-assessment..." 3.1-37(a) 3.1-37(b)			
F 0740 SS=G Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and			

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	psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.			
	Based on interview and record review, the facility failed to implement their Behavior Management policy and review and revise behavioral health care plans, which had not been effective, for a resident's behavior of rummaging for linens and combativeness, which resulted in escalating physical behaviors and the resident being sent to the emergency room for due to pain and swelling of her left ankle and arm. (Resident 55, 30 and 37). Findings include: 1. The clinical record for Resident 55 was reviewed on 8/3/22 at 10:04 a.m. The Resident's diagnosis included, but were not limited to, mood disorder, expressive and receptive aphasia (inability to speak or understand what is said), and dementia with behavioral disturbances. A Quarterly MDS (Minimum Data Set) Assessment, completed 3/11/22, indicated she had unclear speech, and was usually able to understand what was said to her. She was sometimes able to make herself understood and was severely cognitively impaired. A care plan, last revised on 4/26/22, indicated she had behavioral symptoms such as rummaging through linen closets, yelling, agitation, combativeness such as hitting, kicking, and	F 0740	The facility will ensure this requirement is met through the following corrective measures: 1. Resident #55 no longer resides at the facility. Residents #30 and #37 have been reviewed and behavioral care plans have been revised. 2. Residents exhibiting behaviors have the potential to be affected. Those behavior care plans have been reviewed/revised as indicated. 3. The Behavior Management policy was reviewed and no changes were indicated. Staff will be re-educated on this policy. The Social Services Director or her designee will review 2 random behavior care plans and associated behaviors weekly to ensure the plan is followed and it's efficacy, updating as indicated, for 6 weeks and until 100% compliance is achieved, then 5 care plans monthly for 6 months and until 100% compliance is maintained. 4. The findings of these reviews will be presented during the facility's monthly QAPI meeting and the plan of action adjusted accordingly.	09/07/2022

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	slapping, disrobing, throwing bed linens, refusal of care and medications, refusing to allow staff to take meal trays or clean her room, and only allowing certain certified nursing assistants to provide care for her. She had a diagnosis of mood disorder. The goal was for her behavioral symptoms to be managed through her care plan interventions. The interventions were to allow her to express her feelings, created 4/20/21, approach her from the front and make sure to have her attention, created 4/20/21, not to rush her and allow her time to express her wants, created 6/14/21, explain that my behaviors are not appropriate, created 4/20/21, if she was choosing not to have care to come back at a later time and re-approach, created 4/20/21, offer her alternative care choices to achieve the same outcome, created 4/20/21, Offer to change her brief using the stand-up lift rather than in bed, created 6/14/21, implement her communication care plan, created 4/20/21, medications as ordered, created 4/20/21, mental health services as indicated, created 4/20/21, and when agitated allow her time to calm and reapproach at a later time, created 4/20/21. A psychiatric provider behavioral health follow up evaluation, dated 5/24/22, read "...HPI [sic]: Patient is seen on this date...the patient continues to refuse all medications per staff report. Staff reported the patient has refused all of her medications both tablet and liquid for several months. Staff reported family is aware of this...Patient was calm today, unable to elaborate on issues or concerns. Patient is aggressive at times, refuses all medications. She often isolates to herself/[sic] room. Discussed discontinuing psychotropics with the treatment team as she has refused them for several months and family is aware. Treatment team was aggregable to this today...Plan: 1) Discontinue psychotropic			

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medications as the patient continues to refuse all medications...3) If the patient becomes explosive/ [sic] unable to redirect her, please consider having admitted to an inpatient psychiatric unit..."

A behavior sheet, dated 5/26/22 at 4:03 p.m., indicated she had displayed the behaviors of hitting others, scratching others two to three times. The intensity of the behaviors was severe. The interventions used to decrease the behavior were to approach in a calm manner, which did not change the behavior. The interventions of not arguing or confronting her and replacing the certified nursing assistant with additional staff had shown an improvement in the behavior. The comments were that the behavior had occurred when she was being "washed on the toilet". She had expressive aphasia and continued to attempt "nonsensical communication".

A nurse note, dated 6/9/22 at 6:01 p.m. read "resident went behind the wall of nurses station,[sic] to remove linen off of cart,[sic] cna[sic] told resident that she could not remove anything off of cart,[sic] resident started pulling linen cart in hallway,[sic] cart leaning[sic] resident grab[sic] cart and cna[sic], another cna[sic] had to assist cna[sic], resident had pad in her hand swung[sic] around and hit this nurse in the face, resident seen earlier removing several sheets[sic] gowns and pads of[sic] linen closet and taking to her room,[sic] placed call to unit manager to inform of situation. placed[sic] call to daughter had[sic] to leave message to call facility as soon as possible. unit[sic] manager called this writer after speaking with director of nursing 911[sic] was called to transport resident to hospital for evaluation. daughter[sic] returned call was[sic] informed of situation, stated that she was on her way. 911[sic] arrived resident[sic] would not let

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this writer or 911[sic] entered[sic] room, daughter arrived [sic] would not let her in at first [sic] eventually allowed daughter in room, eventually resident placed on stretcher and transported to ...emergency room..."

A behavior sheet, dated 6/9/22, at 9:55 p.m., indicated she had displayed the behaviors of hoarding, hitting others, scratching others, and grabbing others. The intensity of the behaviors was severe. The interventions used to decrease the behaviors were to approach in a calm manner, identify self, establish eye contact, call her by name, use simple sentences, not to argue or confront, and talk with her. The behaviors remained unchanged using these interventions. The comment were that she was sent out for a psychiatric evaluation.

An acute care hospital emergency department provided notes, dated 6/9/22 at 6:18 p.m., indicated Resident 55 presented to the emergency department for evaluation of pain in her right ankle and right shoulder. She was in an altercation with her staff from her facility. She had mild swelling over her right ankle. The Xray results did not show acute fracture or dislocation. She returned to the facility from the Emergency Department visit.

An Individualized Mental Health Safety Plan, dated 6/9/22, indicated she had been seen by a behavioral health crisis center. Her early warning signs that a crisis may be developing were communication issues. She had both expressive and receptive limits due to a history of a stroke and aphasia and conflicts with staff who are "not skilled at solving problems or resolving conflict amicably". Her coping strategies were deep breathing, removing herself from the stress or

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conflict, listening to music, and distraction.

The coping strategies had not been added to the care plan for behaviors.

A nurse note, dated 6/28/22 at 10:15 p.m., indicated she was in the linen closet and was told staff would get her what she wanted. She was not to go into the linen closet. She started to swing at the nurse and nursing assistants in an aggressive manor. She refused care from all staff.

A nurse note by LPN (Licensed Practical Nurse) 22, dated 7/25/22 at 4:30 a.m., read "Pt[sic] was upset about it[sic] not being any pads on the unit and having a sheet on her bed instead. She was in[sic] chair and proceeded to go to the linen closet and both linen bins in hall to look[sic] herself. I went over to 100 hall to get pads out the closet for her,[sic]she wasn't happy with me getting the pads. [sic]And proceeded to go in other patients rooms looking for pads. I found her in another residents room, room number...taking there[sic] pad and i[sic] took the pad from her and she proceeded to swing and try and[sic] fight me. I was trying to get her out[sic] the residents room and she proceeded to hit and swing on[sic] me as i[sic] pulled her wheelchair from the back to removed her from his room. She stood in front of his door turning[sic] knob trying to reenter[sic], I was holding the door so she couldn't enter. I had to end up going through the residents bathroom and coming out of another room, room... to get away from her. She kept going into different residents rooms and when i[sic] was pulling her out she was fighting and swinging at me. I ended up having to go into another residents room... to keep her from being violent with me,[sic] I went through the bathroom and came out... to get away from her. I myself [sic]and the other aides tried to

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accommodate her and she refused care from everyone. I tried to talk and accommodate[sic] to her but she was chasing me and being violent."

A nurse note, dated 7/25/22 at 10:59 a.m., indicated a new physician's order was received to send Resident 55 to the emergency room for evaluation and treatment due to pain and swelling to left ankle and arm.

An Emergency Department Provider Note, dated 7/25/22 at 10:08 a.m., indicated Resident 55 was seen for evaluation of arm injury that was first noticed this morning. EMS (Emergency Medical Services) reports picking her up at her nursing home where she was found on her bed and complained of right wrist swelling, left ankle pain, and left ring finger pain. According to the EMS the nursing home does not know what transpired. The clinical impression was left ankle swelling, left hand pain, swelling of right wrist, and alleged assault.

On 8/8/22 at 10:33 a.m., the Executive Director provided the Behavior Management Record for Resident 55 for June and July 2022 which indicated she had the diagnosis of mood disorder with depressive features and vascular dementia with behavioral disturbances. The behaviors she was known to exhibit were combativeness, refusal of care and medications, rummaging and hoarding, yelling, and screaming, and throwing objects. Behaviors of rummaging, hoarding, and combativeness were documented as occurring on the following days:
6/9/22- behavior of combativeness, refusal of care or medications, rummaging and hoarding. The reason for the behavior was unknown. The approaches uses were to identify self, approach calmy. make eye contact, talk calmly, and leave

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	and then return, which were not effective. She was sent out 911. 6/13/22- behaviors of combativeness and refusal of care or medications. The reason for the behavior was unknown. The approaches used were to approach and speak calmly and call daughter, which were not effective. 6/29/22- behaviors were noted to occur at 3 different times of day. the behaviors displayed were combativeness and refusal of care or medications. The reasons for the behaviors were unknown. The approached used were to call daughter, leave and reapproach in a few minutes, approach calmly, which was effective 1 of the 3 times. 7/6/22- behavior of combativeness. The reason was toileting. The approaches used were to talk calmly and review care being given, which were effective. During an interview on 8/3/22 at 9:36 a.m., FM (Family Member) 20 indicated that Resident 55 had begun having behaviors about linen when the facility rules changed, and she was no longer able to go to the linen closets to get her own linens. Resident 55 did not understand why she could not continue to get the linens on her own. She had been sent to the emergency room after a "tussle" about linens in June 2022. The facility had called the police on her that time, and she was sent for a psychiatric evaluation. On 7/25/22 there was another "tussle" over linens. They had taken the pad she had found from her. Resident 55 had said they were "physical" with her and were pulling her wheelchair back. Her hand and ankle were swollen. The morning after it happened, she was in pain and had one of the nursing assistance call me, during the conversation she complained of pain in her arm. FM 20 then requested the nursing assistant to tell the nurse to send			

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Resident 55 to the hospital. The nurse called FM 20, wondering why Resident 55 needed sent to the hospital. FM 20 told her about Resident 55's pain in her hand. Resident 55 was then sent to the emergency room. While she was at the hospital Resident 55 expressed, she was afraid to return to the facility. FM 20 had reached out to find out answers about what happened in June but is seemed to her that the facility was blaming Resident 55 for the problem. If her bed wasn't made the way she wanted it, what was she expected to do.

During an interview on 8/4/22 at 11:02 a.m., LPN 22 indicated she was the nurse caring for Resident 55 on the night of 7/25/22. She had went to another unit to get a pad for Resident 55's bed. When she returned, Resident 55 did not want the pad she had brought. Resident 55 had gone into another resident's room and had found a pad. LPN 22 had noticed that Resident 55 had some of the other resident's clothes in her hand along with the pad. LPN 22 took the pad and clothing out of Resident 55's hand. Resident 55 "targeted" LPN 22 after taking the items. Resident 55 started swinging her left hand and came after LPN 22. LPN 22 was attempting to pull Resident 55's wheelchair from behind to remove her from another resident's room. Resident 55 had tried to hit LPN 22 and LPN 22 had to let go of the wheelchair and move around to keep from getting hit by Resident 55. After LPN 22 had removed Resident 55 from the other resident's room, Resident 55 tried to re-enter the room. LPN 22 went into the room and shut the door LPN 22 held the other resident's room door closed with her foot. She waited for a little while and exited through an adjoining room. When LPN 22 came back into the hallway, she noticed that Resident 55 was trying to go back into the other resident's room. LPN 22 went back into the other

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resident's room and shut the door again. Resident 55 was beating at the door trying to get into the room. LPN 22 stayed in the other resident's room for a couple of minutes and then exited through the adjoining room again. Resident 55 saw LPN 22 exit the adjoining room and "focused" on LPN 22 and came down the hallway after LPN 22 backing her into a different room. LPN 22 shut the door of the room and Resident 55 started "beating" at the door and yelling. LPN 22 went through an adjoining room and came back into the hallway. LPN 22 attempted to talk with Resident 55 to calm her but was unsuccessful and left the unit to find help. Other staff went to try to help Resident 55 but were not successful. LPN 22 explained that staff always "get into it" with Resident 55 about the linen carts. Resident 55 would "charge" at them when they redirected her from the carts. The staff would try to talk with Resident 55 when she was having behaviors and try to diffuse the situation by accommodating her needs. Resident 55 displayed the worst behaviors when trying to get linens. The staff took her day by day with Resident 55.

During an interview on 8/4/22 at 11:37 a.m., CNA (Certified Nursing Assistant) 23 indicated she had been caring for Resident 55 on the night of 7/25/22. She had assisted Resident 55 with incontinent care and gotten her into her wheelchair while changing her bed. CNA 23 had put a clean sheet on the bed but did not have a pad available to use. CNA 23 explained to Resident 55 that she would bring one when the linen was delivered from laundry. Resident 55 had refused to get back into bed. LPN 22 had gone to a different unit to get a pad for the bed. CNA 23 had left the room and went to provide care for another resident. CNA 23 had not witness the incident between Resident 55 and LPN 22. She

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was told about it after it happened and went to try to assist Resident 55, but Resident 55 had gone back to her room and refused care.

During an interview on 8/5/22 at 9:21 a.m., LPN 24 indicated Resident 55 had behaviors daily. She would refuse care and go in and out of other resident's rooms to find linen. The staff would try to provide her with linen, but she would not always take it from them. LPN 24 had never witness any staff member be abusive toward Resident 55 but had witnessed Resident 55 hitting staff.

During an interview on 8/5/22 at 9:28 a.m., LPN 25 indicated Resident 55 would often have behaviors, she would throw things at the staff and start screaming and that she had seen the staff display a lot of patience while caring for Resident 55.

During an interview on 8/5/22 at 9:44 a.m., the SSD (Social Services Director) indicated Resident 55's behaviors were reviewed in IDT's (Interdisciplinary Team) morning stand up meeting almost daily. She reviewed the behaviors on a daily basis. Most of Resident 55's behaviors involved refusing care and there were behaviors about linens. Every 2 weeks the psychiatric team would meet and go over the residents who needed to be seen. Resident 55's behaviors seemed to be affected by her communication deficit. Resident 55 had trouble communicating her needs to staff but seemed to be able to communicate her needs so that her daughter understood. The staff had tried using the communication book to communicate with her, but she was not able to effectively utilize it. The IDT team reviewed her behaviors and what interventions had worked and were trying to develop a new plan. The only new

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intervention that had been somewhat effective was to call her daughter when she was having a behavior. She had been seen by the psychiatric physician.
2. The clinical record for Resident 30 was reviewed on 8/5/22 at 9:16 a.m. Resident 30's diagnoses included, but not limited to, bipolar disorder and schizophrenia.

Resident 30's quarterly MDS (minimum data set) dated 6/1/22 indicated, Resident 30 was cognitively intact, had no delirium or behaviors.

Resident 30's care plan dated 5/17/22 indicated, she displayed the following behaviors: hitting at others, yelling out, and inappropriate remarks relate to her diagnoses of schizophrenia and bipolar disorder. Interventions included, but not limited to, to receive psychiatric services as needed, social services to intervene when needed, and redirection when behavior begins.

A behavior sheet dated 5/11/22 indicated, "staff walking by patient in [sic] hall. patient[sic] put her hand up as to hit staff,[sic] staff moved out of the way. Therapy staff stated[sic] did you think she was going to hit you.[sic] Staff stated [sic] she hit me the other day. [sic]Patient stated[sic] 'Yes I know I hit you'." The intensity score on the behavior sheet indicated "3". Interventions used and their outcomes were:
- Approached in calm manner; outcome was behavior unchanged
- Identified self; outcome was behavior unchanged
- Established eye contact; outcome was behavior unchanged
The solution was "Staff to avoid contact with patient"

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Resident 30's May MAR (medication administration record) and TAR (treatment administration record) were reviewed 8/5/22 at 9:16 a.m. Neither the MAR nor the TAR contained any documentation of any behavior monitoring for the month of May 2022.

Resident 30's May 2022 behavior tracker under "tasks" in the electronic charting system was received on 8/5/22 at 1:10 p.m. from ED (Executive Director) indicated, on 5/16/22 at 9:55 a.m., Resident 30 displayed no behavior symptoms. Resident 30's behavior tracker for the past 30 days did not contain any documentation.

An interview with CNA (certified nursing assistant) 3 was conducted on 8/05/22 at 10:54 a.m. CNA 3 indicated, Resident 30 still displays some behaviors such as cursing at staff and motioning as though she was going to hit you. CNA 3 stated, when she displayed those behaviors, he would just tell the nurse when they happen.

An interview with LPN (licensed practical nurse) 4 was conducted on 8/05/22 at 10:57 a.m. LPN 4 indicated, when a behavior symptom occurs, the behavior should be documented in the behavior binder or in the electronic charting system as a behavior note.

An interview with DON (Director of Nursing) was conducted on 8/05/22 at 11:06 a.m. DON indicated, the behavior binders on the units contain the behavior care plans, interventions, and a list of known behaviors, but to her knowledge it did not contain behavior notes. She further indicated, if the resident has a behavior, it should be placed in the electronic charting system under the behavior sheet assessment.

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3. The clinical record for Resident 37 was reviewed on 8/3/22 at 10:28 a.m. The diagnoses for Resident 37 included, but was not limited to, stage 4 chronic kidney disease and receptive-expressive language disorder.

A Quarterly Minimum Data Set (MDS) assessment, dated 6/13/22, indicated Resident 37 was cognitively impaired.

A care plan last review date of 6/14/22, indicated "I [Resident 37] have behavioral symptoms such as making inappropriate sexual remarks to staff during care related to a cognitive deficit.

A nursing note dated 5/16/22 indicated "Pt [patient] (Resident 37) noted to have inappropriate sexual advances towards staff on multiple occasions. Expressed per staff and also per spouse..."

A nursing note dated 6/7/22 indicated "...Pt. has expressed sexually inappropriate gestures toward staff. Pt. is mostly redirectable. No aggressive behavior noted."

A behavior sheet dated 6/7/22 indicated Resident 37 had sexually inappropriate behavior. The sheet noted, "...RN [Registered Nurse] not able to determine what contributed to behavior. Behaviors happens in pt. room during care. Remarks are made towards CNA [Certified Nursing Assistant]."

A nursing note dated 8/3/22 indicated "...Resident's was more confused and aggressive today during cares, wife tries to instruct resident during cares while CNA's attempt to do cares on resident, resident seems to get more angry and

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confused trying to listen to his wife and the cna's during cares, cares was completed today."

A nursing note dated 8/4/22 indicated "...Cna states resident was being inappropriate during cares, he felt on her buttocks."

The resident's clinical record did not include behavior sheets on 5/16/22, 8/3/22, or 8/4/22, nor continuing monitoring every shift conducted after each behavior incident.

An interview was conducted with License Practical Nurse (LPN) 22 on 8/5/22 at 10:57 a.m. She indicated she had heard about Resident 37's sexual inappropriate behaviors, but had not observed any incidents herself.

An interview was conducted with the Social Services Director on 8/5/22 at 2:58 p.m. She indicated she was currently working on improvement of the behavior management program.

An interview was conducted with the Director of Nursing (DON) and the Nurse Consultant on 8/5/22 at 3:30 p.m. The DON indicated the staff would complete a behavior sheet after an incident, and then the behavior would be added in the task tab. The behavior would then be monitored and documented in the task tab every shift. She was unable to find any behavior sheets for the 5/16/22, 8/3/22 and 8/4/22 incidents nor monitoring of Resident 37's behaviors conducted every shift.

A Behavior Management Policy was provided by the Executive Director on 8/5/22 at 8:57 a.m. It indicated "...Policy: To ensure the resident receives effective treatment and interventions for behavior and mood symptoms. To ensure the

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	resident is receiving the necessary medication at the lowest effective dose to treat their symptoms. Procedure: 1. The CNA will document behaviors in the Electronic Medical Record when behaviors occur. The CNA will notify the nurse of the behavior. 2. The nurse or social service will complete the behavior sheet upon being notified of or witnessing a behavior...5. Social Services will complete follow-up documentation of behaviors under progress notes. 6. Residents that are on Behavior Management Programs will have documentation of behavior symptoms completed every shift by the nursing staff on Point of Care. This will allow for accurate documentation and assessment of the resident's behaviors, and therefore appropriate follow-up by the Interdisciplinary team. 7. Residents that have a new behavior will have documentation on behaviors on the Point of Care for two weeks to determine if the behavior is ongoing. This will allow for appropriate assessment of the behavior....10. Criteria for the Behavior Management Program would include: a) Behaviors that present a risk of danger or harm to the resident, b) Behaviors that present a risk of danger or harm to others, c) Behaviors that fringe upon the rights of others, or is so disruptive that is interferes with the rights and dignity of others. d) Behaviors that significantly reduce staff ability to provide care..." 3.1-37(a)			
F 0775 SS=D Bldg. 00	483.50(a)(2)(iv) Lab Reports in Record - Lab Name/Address §483.50(a)(2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.			

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	Based on interview and record review, the facility failed to ensure laboratory results were maintained in the clinical record for 1 of 5 residents reviewed for unnecessary medications. (Resident 83) Findings include: The clinical record for Resident 83 was reviewed on 8/9/22 at 9:55 a.m. The diagnoses included, but were not limited to: muscle spasms, mood disorder, hyperlipidemia, hypertension, and delusional disorder. The August, 2022 physician's orders indicated to administer one 5mg tablet of Baclofen twice daily; one 10 mg tablet of escitalopram daily; one 40 mg tablet of Lipitor daily; one 2.5 mg tablet of Norvasc daily; and one 0.5 mg tablet of Risperdal daily. The 5/2/22 Note To Attending Physician/Prescriber read, "Lab Monitoring Recommended. Labs: no recent labs for chronic disease. Recommend specific labs to monitor drugs and disease state to ensure therapeutic efficacy with minimal risk of adverse events. Orders: CMP [complete metabolic panel,,] A1C [blood test that measures your average blood sugar levels over the past 3 months,] lipid panel." The Physician/Prescriber Response section of the note was signed as "agree" on 5/12/22. There were no CMP, A1C, or lipid panel results in the clinical record. The 7/4/22 Note To Attending Physician/Prescriber read, "Lab Monitoring Recommended. Labs: no recent labs for chronic disease. Recommend specific labs to monitor drugs and disease state to ensure therapeutic	F 0775	The facility will ensure this requirement is met through the following corrective measures: 1. Resident #83's lab results were provided to surveyor as requested and placed in the residents electronic chart. 2. All residents who have lab results have the potential to be affected. 3. The Laboratory and Diagnostic policy was reviewed and no changes indicated at this time. Licensed staff educated on this policy and protocol for medical records. The DON or her designee will audit labs to ensure completion and that they have been scanned into the medical record. This will be completed 5x week x 4 weeks until 100% compliance is achieved, then 2x week for 4 weeks and until 100% compliance is achieved, then weekly for 4 weeks and until 100% compliance is achieved, then monthly for three months and until 100% compliance is achieved. 4. Findings of these audits will be reviewed during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	09/07/2022

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efficacy with minimal risk of adverse events. Orders: CMP, A1C, lipid panel." The Physician/Prescriber Response section of the note was signed as "agree" on 7/12/22.

There were no CMP, A1C, or lipid panel results in the clinical record.

On 8/9/22 at 4:20 p.m., the NC (Nurse Consultant) provided the 5/18/22 A1C, CMP, and lipid panel results and the 7/13/22 A1C, CMP, and lipid panel results.

An interview was conducted with the DON (Director of Nursing) on 8/9/22 at 2:50 p.m. She indicated the CMP, A1C, and lipid panel labs were all completed in May, 2022 and then again in July, 2022. She'd been educating staff on the importance of keeping the lab results in the chart. That was probably why pharmacy recommended the same labs be drawn in July, 2022 as they recommended in May, 2022. Not having the results in the chart was causing confusion for everyone.

The Laboratory Test Processing and Reporting policy was provided by the NC on 8/9/22 at 4:09 p.m. It read, "Test results are promptly reported to the physician/clinician who ordered them (or other clinician on call), and their response documented in the medical record."

3.1-49(f)(4)

F 0791
SS=D
Bldg. 00

483.55(b)(1)-(5)
Routine/Emergency Dental Srvcs in NFs
§483.55 Dental Services
The facility must assist residents in obtaining routine and 24-hour emergency dental care.

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	§483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.			

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	Based on observation, interview, and record review, the facility failed to timely address a resident's dental condition for 2 of 4 residents reviewed for dental status and services. (Resident 41 and 57) Findings include: 1. The clinical record for Resident 41 was reviewed on 8/2/22 at 11:45 a.m. The diagnoses included, but were not limited to, chronic pain. He was admitted to the facility on 10/27/21. The 10/28/21 dental consent indicated he consented to receive dental services while at the facility. The physician's orders indicated, "Podiatry, Dental, Audiology, Optometrist and Mental Health Care to evaluate and treat as indicated, effective 10/27/21. The 11/5/21 Admission MDS assessment indicated he did not have any obvious or likely cavities or broken natural teeth. The 6/9/22 Quarterly MDS assessment indicated he had a BIMS (brief interview for mental status score) of 15, indicating he was cognitively intact. An observation and interview was conducted with Resident 41 on 8/2/22 at 11:58 a.m. He opened his mouth and had several missing teeth, broken teeth, and brownish black teeth on top and bottom. He indicated he took 7 or 8 pills at a time, when taking his medication, and some of the pills would get stuck in the cavities in his mouth. After taking his medication, an hour or two later, a pill would fall out of a tooth. His teeth were cutting	F 0791	Th facility will ensure this requirement is met through the following corrective measures: 1. Resident #41 was seen by the facility dentist on 8/10/22 in his room. Resident is scheduled to be seen in facility clinic on next visit, 10/11/22, for x-rays. Resident would still like to obtain outside appointment, appoint is scheduled for 9/8/22 . Resident #57 was seen by the facility dentist on 8/10/22, x-rays taken and no follow-up prescribed. 2. All residents requiring dental services have the potential to be affected. Residents will be reviewed to ensure they have received dental services and will be placed on the list to be seen as indicated. 3. The Dental Vision Hearing & Podiatry policy was reviewed and no changes were indicated. The HFA or her designee will check 5 residents per week to ensure dental needs have been addressed for 6 weeks and until 100% compliance is achieved, then 5 per month for 6 months and until 100% compliance is maintained. 4. The findings of these reviews will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	09/07/2022

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into his gums, and it was causing him pain. He informed nursing about it the previous week, and was told they would schedule an appointment for him, but no one ever followed up with him.

An observation of Resident 41's oral cavity was made with the Case Manager and RN (Registered Nurse) 15 on 8/4/22 at 2:29 p.m. The Case Manager indicated she saw a broken tooth in the front of his mouth. Resident 41 informed the Case Manager and RN 15 the pain came from the cuts in his mouth, if he took a cold drink, ate something hot, chewing, biting his lip, teeth cutting into his gums, trying to close his mouth, and clenching his teeth. He stated, "It's just not good, you know."

The 7/28/22 NP (Nurse Practitioner) note read, "Pt [Patient] does request dentist appt [appointment] for oral pain and cracked teeth. No s/s [signs/symptoms] of dental infection....Assessment and Plan: ...8. Cracked tooth - Outpatient dental referral."

The physician's orders indicated, "Dentist referral outpatient for cracked tooth pain," effective 7/28/22.

The 7/28/22 nurse's note, written by LPN (Licensed Practical Nurse) 13, read, "Resident has referral to see dentist outpatient d/t [due to] cracked tooth. Spoke with resident and does not have a preference on which dentist to go to. Will find dentist for resident."

An interview was conducted with Resident 41 on 8/4/22 at 11:02 a.m. He indicated no one had yet followed up with him on a dental appointment. He was concerned with how he would get to a dental appointment once scheduled, because he was having wheel chair issues. His mouth began

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bleeding a couple of months ago. He would use the camera on his phone to see from where the blood was coming. He thought it was coming from his right cheek. He mentioned his teeth problems to nursing months ago. His teeth hurt right now. If he at something cold or hot, it was instant pain. He was ready to take a fork and butter knife and do his own surgery. Sometimes he clenched his teeth when startled and during meals, and it hurt.

An interview was conducted with UM (Unit Manager) 2 on 8/4/22 at 11:32 a.m. She indicated she had looked up phone numbers of dentists who accepted Medicaid, and gave the phone numbers to LPN 13 to schedule an appointment for him. She was unsure if an appointment was scheduled. During the interview, UM 2 and LPN 8 reviewed the appointment calendar through November, 2022 and were unable to locate a scheduled dentist appointment for Resident 41.

An interview was conducted with LPN 13 on 8/4/22 at 11:49 a.m. She indicated she left the 7/28/22 dental order and dentist phone numbers in a binder for the next shift to schedule, because she received the order in the late afternoon.

An interview was conducted with UM 2 on 8/4/22 at 1:55 p.m. She indicated she spoke with the evening shift nurse who worked the day the order was received. The appointment was scheduled for 8/5/22 at 12:30 p.m. UM 2 was unsure when the appointment was made.

On 8/4/22 at 1:59 p.m., an interview was conducted with the Office Manager of the dentist office at which Resident 41 had a scheduled appointment. She indicated the appointment was just made today.

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An interview was conducted with Resident 41 on 8/4/22 at 2:25 p.m. He indicated no one had followed up with him on a dentist appointment, was unaware he had one scheduled for the following day, and questioned for what time it was scheduled.

On 8/4/22 at 11:15 a.m., the ED (Executive Director) provided a list of residents who saw or were scheduled to see the facility dentist since 5/1/22. Resident 41 was on the list to be seen as a new patient on 8/10/22.

An interview was conducted with Resident 41 on 8/8/22 at 2:55 p.m. He indicated no one informed him he was scheduled to see the facility dentist on 8/10/22, and had never seen the facility dentist previously.

An interview was conducted with the SSD (Social Services Director) on 8/5/22 at 3:13 p.m. She indicated the dental provider put Resident 41 on the list to be seen on 8/10/22. She was unsure how newly admitted residents were placed on the list to be seen when Resident 41 was admitted in October, 2021, because she didn't work at the facility yet. Her process was to put residents on the list to be seen right away after admission, if they consented to be seen.

2. The clinical record for Resident 57 was reviewed on 8/2/22 at 12:11 p.m. The Resident's diagnosis included, but were not limited to, diabetes and anxiety.

An Admission MDS (Minimum Data Set) Assessment, completed 10/4/2021, indicated the was cognitively intact and he had no broken natural teeth.

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A physician's progress note, dated 3/3/22, indicated he had poor dentition and needed a dental referral.

A physician's progress note, dated 4/26/22, indicated Resident 57 complained of a of a broken tooth which had developed swelling and tenderness around the tooth and was having pain while chewing. The assessment and plan was that he had a toothache and a dental abscess. A dental appointment was to be made by the facility. OraJel gel was ordered to be given every 4 hours as needed. Augmentin (antibiotic) was to be given twice daily for 7 days.

A physician's progress note, dated 5/3/22, indicated he was being seen for a follow up of his dental infection. The assessment and plan was to schedule a dental appointment and continue the use of the Orajel and Augmentin.

A physician's progress note, dated 7/5/22, indicated that he had a cracked tooth, and a dental appointment was to be made as soon as possible.

A physician's order, dated 7/5/22, indicated he was to receive Xylocaine Dental Solution (pain medication) every 3 hours as needed for oral pain or discomfort for 14 days.

A physician's progress note, dated 7/14/22, indicated he reported oral abnormalities and teeth abnormalities. The assessment and plan were that he had a cracked tooth, and a dental appointment was to be scheduled as soon as possible.

During an interview on 8/2/22 at 12:11 p.m., Resident 57 indicated he had been asking to see a dentist for several months. His teeth were cracked and breaking off. He had been told there was no

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	way to get him to the dentist because his wheelchair would not fit in the facility bus. On 8/2/22 at 12:11 p.m., Resident 57's teeth were observed. The molars on the left were cracked and black in appearance. During an interview on 8/5/22, the SSD (Social Service Director) indicated she had been made aware of his need to see the dentist on 7/14/22. There were limited choices available to him for transportation to the dentist due to the size of his wheelchair. He had been scheduled to see the in-house dentist on 8/10/22. On 8/8/22 at 10:27 a.m., the Executive Director provided the Dental, Vision, Hearing, Podiatry Services Policy, last revised on 7/2018, which read "... It is the policy of this facility to assure all residents with dental, vision, hearing, or podiatry needs are seen by the Consultants in these areas...11. The facility will assist a resident in arranging for transportation and from outside ancillary service providers as recommended..." 3.1-24			
F 0886 SS=F Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:			

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	155628	A. BUILDING 00 B. WING	08/09/2022

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	§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident’s testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent			

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	the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.			
	Based on interview and record review, the facility failed to initiate outbreak testing timely by not testing staff members with signs/symptoms of COVID-19 immediately thus increasing the potential exposure risk to nursing home residents who resided in the facility. (123 residents) Findings include: The Employee Heath Line Listing was provided on 8/9/22 at 2:35 p.m. by DON (Director of Nursing). It indicated, the following staff members had signs/symptoms of COVID-19, the dates the signs/symptoms began, what the sign/symptoms were, and their respective POC (Point of Care) COVID-19 testing dates: - SM (Staff Member) 1; slight cough started on 6/27/22; tested positive for COVID-19 on 7/1/22. - SM 2; slight cough started on 6/28/22; tested positive for COVID-19 on 7/1/22. - SM 3; slight cough started on 6/29/22; tested positive for COVID-19 on 7/5/22. - SM 4; sneezing and cough on 7/4/22; tested positive for COVID-19 on 7/5/22.	F 0886	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were directly affected by the alleged deficient practice 2. All residents have the potential to be affected. See below for corrective measures. 3. The COVID 19 Testing policy was reviewed and no changes were indicated. Education initiated on the COVID 19 testing policy. A performance improvement tool initiated. The DON/IP/ or designee will complete audit of COVID 19 testing and staff symptoms twice weekly for 4 weeks and until 100% compliance is achieved, then twice monthly for 5 months until 100% compliance	09/07/2022

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	- SM 5; allergy like symptoms on 7/6/22; tested positive for COVID-19 on 7/12/22. The facility provided a list of all staff members and their COVID-19 vaccination status on 8/2/22 at 1:55 p.m. by ED (Executive Director). According to the vaccination status form, the staff members (SM) vaccination status was as follows: - SM 1 was "completely vaccinated" but the box for booster dose was left blank. - SM 2 was "completely vaccinated" but the box for booster dose was left blank. - SM 3 was "completely vaccinated" but the box for booster dose was left blank. - SM 4 was "completely vaccinated" but the box for booster dose was left blank. - SM 5 was "completely vaccinated" but the box for booster dose was left blank. The facility began outbreak testing on 7/8/22. The ED provided the list of 100 hallway residents that were tested for COVID-19 on 7/8/22 on 8/9/22 at 3:50 p.m. A list of residents of confirmed COVID-19 cases in the last four weeks was provided by ED on 8/9/22 at 3:50 p.m. The list identified 3 residents with confirmed positive tests for COVID-19 which were contracted while in the facility. The respective COVID-19 positive dates and units they resided on were as follows: - 7/2/22; 300 hallway - 7/4/22; 400 hallway - 7/14/22; 300 hallway An interview with DON (Director of Nursing) conducted on 8/9/22 at 3:46 p.m. indicated, no COVID-19 outbreak testing was performed on the 200, 300, or 400 hallways at that time because the contact tracing the facility had performed		is maintained. 4. The findings of these audits will be reviewed during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	indicated the first few staff members who came up positive were traced back to where they thought they had possibly contracted the virus and worked primarily on the 100 hallway. DON indicated, it wasn't until a couple of other staff member's, who did not primarily work on the 100 hallway, COVID-19 tests came back positive on 7/5/22 that she thought to start outbreak testing. A COVID-19 Testing of Staff and Residents policy was received on 8/9/22 at 3:30 p.m. from DON. The policy indicated, "Testing...Individuals tested...Prioritizing Individuals for testing should begin with individuals with signs/symptoms of COVID-19 first, and then perform testing triggered by an outbreak...Staff with symptoms or signs of COVID-19, regardless of vaccination status, must be tested immediately and are expected to be restricted from the facility pending the results of COVID-19 testing. If COVID-19 is confirmed, staff should follow Centers for Disease Control and Prevention (CDC) guidance "Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2"[sic]...Testing of Staff and Residents in Response During an Outbreak Investigation A new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a resident triggers an outbreak investigation...Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately."			