STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 00 B. WING	04/30/2024

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SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00429414, IN00429590, and IN00432085. Complaint IN00429414 - Federal/State deficiencies related to the allegations are cited at F552, F697, F732, F757, F921, and F925. Complaint IN00429590 - Federal/State deficiencies related to the allegations are cited at F552, F697, F732, F757, F921, and F925. Complaint IN00432085 - No deficiencies related to the allegations are cited Survey dates: April 28, 29, and 30, 2024 Facility number: 000369 Provider number: 155530 AIM number: 100275190 Census Bed Type: SNF/NF: 80 Total: 80 Census Payor Type: Medicare: 4 Medicaid: 58 Other: 18 Total: 80 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/7/24.	F 0000		
F 0552 SS=D	483.10(c)(1)(4)(5) Right to be Informed/Make Treatment			

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

LaRena Steinhaus 05/30/2024

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

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Bldg. 00	Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.			
	Based on record review and interview, the facility failed to ensure the right of a resident/Guardian to direct his or her own medical treatment, related to medication given after the legal Guardian expressed she did not want the treatment to continue, for 1 of 3 residents reviewed for resident rights. (Resident B) Finding includes: Resident B's record was reviewed on 4/29/24 at 11:41 a.m. The diagnoses included, but were not limited to, dementia and osteoarthritis. A court appointed guardianship, dated 9/29/22, indicated there were two Permanent Co-Guardians appointed for the resident.	F 0552	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Currently resides in the facility. MD/NP Progress Notes / Visit Notes were reviewed to ensure that all orders have been received and transcribed accurately. Current medication orders were reviewed with the resident/guardian to ensure that the resident/guardian agreed with the current medication regimen.	05/30/2024

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	A Physician's Order, dated 3/8/24, indicated Remeron (antidepressant) 15 mg (milligrams) was to be given nightly at bedtime for major depressive disorder. A Psychiatric Nurse Practitioner's (NP) Progress Note, dated 3/8/24, indicated a call was received from the Director of Nursing (DON) in regards to the resident having had a significant weight loss, comments about wanting to die, and a decreased appetite. An order for Remeron 15 mg to be administered at bedtime was given and the resident's weight was to be monitored. A Nurse's Progress Note, dated 3/8/24 at 12:18 p.m., indicated one of the Co-Guardian's was notified of the new medication order for the Remeron and all questions and concerns were addressed. A Psychiatric (Psych) NP Progress Note, dated 3/12/24, indicated a decreased appetite, weight would be monitored, and the Remeron was discontinued related to family refusal of the treatment. There was no order in the resident's Physician Orders from 3/8/24 to 3/12/24, that indicated the Remeron had been discontinued. A Psych NP Progress Note, dated 3/14/24, indicated a routine follow-up visit was completed. The NP spoke with the the Resident's Co-Guardian in regards to the Remeron. The Co-Guardian indicated she had not wanted the Remeron treatment for the resident. The Co-Guardian was educated on the risks and benefits of the Remeron and the treatment was still declined.		**How other residents having the potential to be affected by the same deficient practice will be identified, and what corrective action(s) be taken?** All residents have the potential to be affected by this alleged deficiency. MD/NP Progress Notes / Visit Notes of all current residents will be reviewed to ensure that all orders have been transcribed accurately from 4-1-24 forward. All new medication orders, from 4-1 24, will be reviewed to ensure that the resident/guardian has been notified of the order and is in agreement with the order. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur?** MD NP will provide DNS/designee with all medication order changes in writing. UM/designee will be educated to review MD/NP visit notes daily in the morning clinical meeting to ensure all medication orders have been received and transcribed correctly. UM/designee will be educated to review MD/NP new orders daily in the morning clinical meeting to ensure the resident/guardian has been notified and agreed to the new medication order.	

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	The Medication Administration Records, dated 3/2024 and 4/2024, indicated the Remeron was still being administered every evening from 3/8/24 to 4/28/24. During an interview on 4/29/24 at 3:12 p.m., the DON indicated she had spoken to the Psych NP and an order for the Remeron to be discontinued had not been written, as she had thought the nurse at the facility had already discontinued the Remeron. The DON indicated the NP's would usually put their own orders in the computer. This citation relates to Complaints IN00429414 and IN00429590. 3.1-4(d)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee will audit 5 random residents with new MD/NP visit Progress Notes / Visit Notes to ensure that all new visit notes have been reviewed to ensure that all new medication orders have been communicated with nursing staff and transcribed correctly. DON/designee will audit 5 random residents' new medication orders to ensure that the resident/guardian has been notified and agrees with the new medication order. Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed?** 5-30-24	

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F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a resident with pain received a routine pain medication as ordered by the Physician, related to not re-ordering the pain medication from the Pharmacy in a timely manner for 1 of 1 resident reviewed for pain medications. (Resident B) Finding includes: Resident B's record was reviewed on 4/29/24 at 11:41 a.m. The diagnoses included, but were not limited to, dementia and osteoarthritis. An Annual Minimum Data Set assessment, dated 12/27/23, indicated a moderately intact cognitive status and pain status had not been assessed. A Care Plan, dated 1/27/23 and revised on 3/6/24, indicated pain was present in the resident's lower back with a medical history of osteoarthritis, and the resident's family would sometimes administer pain medications to the resident during a leave of absence from the facility. The interventions included pain medications would be administered as ordered. A Pain Assessment, dated 3/18/24, indicated pain was frequently present. The pain affected her sleep at night and limited her day to day activities. The pain was rated a 5 out of 10 and she had daily	F 0697	**F 697 Pain Management** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident remains in the facility Audit of the resident's narcotic pain medication that is currently in-house to ensure an adequate amount of medication is available." **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All current residents have the potential to be affected by the alleged deficient citation. Audit of all residents receiving narcotic pain medications was completed to identify residents who may need a new script for narcotic pain medication. Completed an audit of last ordered narcotic pain medication to ensure there is no delay in receipt for pain medication from	05/30/2024

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	complaints of pain. Pain management included acetaminophen-codeine (acetaminophen #3) 300-30 mg (milligrams) and repositioning as needed. A Physician's Order, dated 7/14/23 and discontinued on 3/7/24, indicated acetaminophen #3 was to be administered every eight hours related to pain. The medication was scheduled for 12 a.m., 8 a.m., and 4 p.m. The Physician's Order for the acetaminophen #3 was revised on 3/7/24, and the scheduled times for the administration were changed to 4 a.m., 12 p.m., and 8 p.m. The Medication Administration Record (MAR), dated 3/2024, indicated the acetaminophen #3 had not been given on 3/7/24 at 12 a.m. and 3/8/24 at 4 a.m. and 8 p.m. The MAR, dated 3/2024, indicated the acetaminophen #3 had been given on 3/6/24 at 8 a.m. and 4 p.m. and 3/7/24 at at 8 a.m. and 12 p.m. The Controlled Drug Records, dated 2/2/24 and 3/8/24, indicated the last dose of acetaminophen #3 had been administered on 3/6/24 at 12 a.m. The acetaminophen #3 had not been administered again until 3/9/24 at 12 a.m., after the delivery of the medication. The Administration Progress Notes, dated 3/7/24 at 12:39 a.m., 3/8/24 at 4:06 a.m., and 3/8/24 at 6:47 p.m., indicated the acetaminophen #3 had not been available for administration. There was no documentation in the Nurses' Progress Notes, that indicated the family had administered pain medication to the resident from		pharmacy. Education to nursing staff of need / importance of ensuring scripts are received to prevent delay in narcotic pain medication administration. Education to nursing staff on controlled substance orders policy. Education to nursing staff on ordering medications policy. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Education to nursing staff of need / importance of ensuring scripts are received to prevent delay in narcotic pain medication administration. Education to nursing staff on controlled substance orders policy. Education to nursing staff on ordering medications policy. Unit Managers will be educated on the need to monitor script renewal and narcotic pain medication administration on their unit. • **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** • DON / designee will complete audits on 5 random residents with ordered narcotic	

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	3/6/24 at 12 a.m. through 3/9/24 at 12 a.m. During an interview on 4/29/24 at 4:49 p.m., the Director of Nursing (DON), indicated the acetaminophen #3 had not be given on 3/6/24 at 8 a.m. and 4 p.m., 3/7/24 at at 8 a.m. and 12 p.m. and this had been an error in documentation. She indicated the resident had gone two days without the acetaminophen #3 and controlled substances required a prescription to be refilled. During an interview on 4/30/24 at 9:33 a.m., the DON indicated the acetaminophen #3 had not been re-ordered until 3/7/24. The Pharmacy had to obtain a prescription, which was received on 3/8/24, and the medication was delivered early morning on 3/9/24. The acetaminophen #3 should have been re-ordered when the medication was getting low. This citation relates to Complaints IN00429414 and IN00429590. 3.1-37(a)		pain medication to ensure that the residents are receiving medication as ordered and controlled substance policy/ordering medications policy is being followed and documented per policy. • Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed.** • 5/30/2024	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly			

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	responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, record review, and interview, the facility failed to ensure the posted Nurse Staffing Information was up-to-date and current, related to Nurse Staffing Information not posted daily and a lack of of actual hours worked documented on the postings. This had the potential to affect all of the residents who resided in the facility in February, March, and April, 2024. Finding includes:	F 0732	**Whatcorrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** DON educated on the Daily Staffing Posting Policy A new template was developed and implemented with all the regulatory information required.	05/30/2024

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	During an observation on 4/28/24 at 8:15 a.m., the Nurse Staffing Information was located in a locked glass frame on the wall across from the Main Entrance. The date on the Nurse Staffing Information was 4/19/24. During an interview on 4/28/24 at 11:10 a.m., the Administrator indicated the staff member who completed the form was on vacation and no one else had the key to the locked frame. During an interview on 4/29/24 at 10 a.m., the Director of Nursing (DON), indicated she had found the past postings in the box for papers to be shredded. The the Scheduler had not known she was supposed to keep the postings. Nursing schedules and posting information, dated February 20, 2024 to March 20, 2024 and April 15 - 30, 2024 were reviewed on 4/29/24 at 5 p.m. The postings for March 1 & 2, 2024 were not available to be reviewed. The Nurse Staffing Information included how many RN's, LPN's, non-licensed staff were scheduled each day on each shift. The actual hours worked were not included on the postings. During an interview on 4/30/24 at 9 a.m., the Regional Nurse Consultant indicated the actual hours worked were not on the postings. This citation relates to Complaints IN00429414 and IN00429590.		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All current residents have the potential to be affected by the alleged deficient citation. Template change of current daily nurse staffing sheet. Education of facility scheduler on the Daily Staffing Posting Policy **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Template change of current daily nurse staffing sheet. Education to facility scheduler on facility requirement to maintain daily nurse staffing sheets for a minimum of 18 months, or as required by State law, whichever is greater. Education to scheduler/nursing staff on Regulation 483.35. Education to scheduler /nursing staff on Daily Staffing Posting Policy Education to scheduler/nursing staff on schedule accessibility. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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			into place. DON/designee will complete audits daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters to ensure that the daily nurse staffing schedule is accurate and accessible per regulation. Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **By what date the systemic changes for each deficiency will be completed.** 5/30/2024	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-			

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	§483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on observation, record review and interview, the facility failed to ensure residents were free from unnecessary medications, related to medications administered when the blood pressure was out of prescribed parameters and multiple pain patches applied to a resident, for 2 of 2 residents reviewed for unnecessary medications. (Residents B and F) Findings include: 1. During an observation on 4/28/24 at 9:26 a.m., Agency LPN 1 was administering Resident B's morning medications, which included a Lidocaine patch 4% (pain patch). The resident was observed to have undated patches on her right upper arm, right hip, right thigh, right outer buttock, and her right upper buttock. Agency LPN 1 indicated there were no dates on the patches and that the resident had "a lot of pain". She then placed the dated lidocaine patch on the resident's lower back.	F 0757	**Whatcorrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A head to toe assessment was completed on the resident to ensure that the resident had the correct amount of ordered medication patches placed on her person. Education of residents' blood pressure medication parameters was completed with nursing staff to ensure they knew when to give and when to hold the ordered medication based on the ordered parameters medication **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	05/30/2024

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	Resident B's record was reviewed on 4/29/24 at 11:41 a.m. The diagnoses included, but were not limited to, dementia and osteoarthritis. An Annual Minimum Data Set assessment, dated 12/27/23, indicated a moderately intact cognitive status and pain status had not been assessed. A Care Plan, dated 1/27/23, indicated the resident's Guardian would place pain patches on the resident. The interventions were to check the resident for additional patches on the body and educate the Guardian of the negative outcomes. A Care Plan, dated 1/27/23 and revised on 3/6/24, indicated pain was present in the resident's lower back with a medical history of osteoarthritis, and the resident's family would sometimes administer pain medications to the resident during a leave of absence from the facility. The interventions included pain medications would be administered as ordered. A Pain Assessment, dated 3/18/24, indicated pain was frequently present. The pain affected her sleep at night and limited her day to day activities. The pain was rated a 5 out of 10 and she had daily complaints of pain. Pain management included acetaminophen-codeine (acetaminophen #3) 300-30 mg (milligrams) and repositioning as needed. A Physician's Order, dated 8/12/23, indicated a Lidocaine Patch 4% was to be applied to the lower back daily for back pain. The Manufacturer's Instructions, located on the back of the Lidocaine Patch packet, indicated to not use more than one patch at a time.		**action(s) will be taken.** All current residents have the potential to be affected by the alleged deficient citation. Audit of all residents receiving blood pressure medications with parameters Audit of all residents receiving lidocaine patches Education to nursing staff on correctly following BP medication orders with parameters. Education to nursing staff on correct lidocaine patch administration Education to nursing staff on the need to complete an assessment on residents who return from a loa for the presence of unordered medications/patches. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Unit Managers will be educated on the need to monitor BP medication administrations with parameters for compliance and accuracy. Education to nursing staff on correctly following BP medication orders with parameters. Upon a resident's return from LOA, an assessment will be completed for the presence of unordered medications/patches. UM will monitor this daily in the	

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	During an interview on 4/30/24 at 9:28 a.m., the Assistant Director of Nursing indicated the family would put extra patches on her when they took her out of the facility for a visit and the staff were to remove the extra patches when she returned to the facility. 2. Resident F's record was reviewed on 4/30/24 at 9:30 a.m. The diagnoses included, but were not limited to stroke and dementia. A Physician's Order, dated 4/20/23, indicated Midodrine HCI (used for hypotension), 5 milligrams daily was to be given. The medication was to be held if the systolic blood pressure was greater than 120 and diastolic blood pressure was greater than 80. The Medication Administration Record, dated 4/2024, indicated the Midodrine was administered on April 6, 2024 with a blood pressure of 127/69, April 12, 2024 with a blood pressure of 142/70, April 15, 2024 with blood pressure of 139/70, and April 20, 2024 with a blood pressure 151/66. During an interview on 4/30/24 at 9:49 a.m., the Director of Nursing indicated the medication was given outside of the Physician's ordered parameters. This citation relates to Complaints IN00429414 and IN00429590. 3.1-48(a)(1) 3.1-48(a)(6)		morning clinical meeting. UM will monitor residents with medication parameters daily in morning clinical meetings to ensure medication parameters have been followed accurately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** DON/designee will complete audits on 5 random residents with ordered blood pressure medications requiring parameters for administration to ensure that the residents are receiving medication as. DON/designee will complete audits on 5 random residents with orders for lidocaine patches to ensure manufacturer instructions are on order: ex-one patch on body at a time. Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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			By what date the systemic changes for each deficiency will be completed. **5/30/2024**	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure the residents' environment was clean and in good repair, related to dirt and debris in the corners and around the base board in resident rooms and bathrooms, unlabeled/uncovered personal care items stored in the bathroom, dried liquid feeding on pump poles and floors, stains on the floor, dirty and stained privacy curtains, cobwebs, trash on the floor, trash and equipment stored behind closets and in unused bathtubs, dirty unused bathtubs, dim bathroom lights, loose baseboard, missing bathroom tile, holes in the tile floor in the bathroom, and a full water pitcher liner used for urine elimination for 14 of 15 rooms and /or bathrooms observed randomly on 4 of 4 halls. (Rooms 214, 213, 206, 204, 205, 311, 310, 308, 306, 408, 410, 402, 404, and 510.) Findings include: Random observations of resident rooms and bathrooms indicated the following: 1. 200 Hall a. On 4/28/24 at 8:43 a.m., the floor behind the door in room 214 (two residents) was stained and	F 0921	It is the intention of this facility to provide an environment that is clean and in good repair. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** Tube feeding equipment, furniture have been cleaned for rooms 206, 213, and 510. Dirt, debris, and trash have been removed from rooms 205, 231, 214, 308, 310, 311, 402, 408, and 510. Personal items have been labeled for residents in 204, 205, 213, 214, 306, 402, and 408. Floors have been repaired in 204 and 306 bathrooms. Lighting has been repaired in 306 bathroom. Replacement wardrobes have been repaired/ordered for room 408. An outside vendor has been contracted to strip/wax the floors in rooms 205, 213, 214, 308, 310, 311, and 408. **How other residents having the potential to be affected by the same deficient practice will be**	05/30/2024

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	dirty. There was dirt and debris along baseboards and corners of the room. There were cobwebs in the corner by the window. The bathroom, which was shared with room 213 (one resident), was dirty with debris. There was a green plastic container on the floor between the toilet and the wall. b. On 4/28/24 at 9:30 a.m., there was dirt and debris on the floor and along the baseboards of room 213. There was a stain and dirt behind the door to the room. there was dried liquid feeding on the base of the feeding pump pole and on the equipment stored on the bedside dresser. c. On 4/29/24 at 10:17 a.m., there was dried feeding on the base of the feeding tube pole and on the bedside dresser in room 206 (one resident). d. On 4/29/24 at 10:35 a.m., there was dirt and debris in the corners of the room and along the baseboards in room 205 (one resident). The bathroom, which is shared with room 204 (one resident), there two washbasins stored on the floor, uncovered, and unlabeled. There were two bottles without resident names of cleanser in one of the basins. There was an uncovered/unmarked bedpan, wipes, and a graduated container stored on the floor of the bathroom. 2. 300 Hall a. On 4/29/24 at 10:52 a.m., there was dirt and stains on the privacy curtain of the bed by the door in room 311 (two residents). Dirt and debris was under the bed and an opened small packet of potato chips was on the floor of the bed by the door. There was dirt and debris under the bed by the window.		**identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. Facility has hired a new environmental supervisor to oversee the daily cleaning, deep cleaning schedules of all resident rooms. An offer has been accepted for a new Maintenance Director who will be able to oversee and maintain the repairs/replacement of resident rooms and equipment. In the interim outside vendors have been contracted to complete needed floor and furniture repairs, another vendor has been contracted to strip/wax all resident rooms and common tile floors in the facility. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Environmental staff have been educated on daily cleaning tasks, daily documentation of task required and completed, deep cleaning protocols and a schedule for regular deep cleaning going forward. Staff have been educated on how to complete a work order for any repairs needed. The Environmental supervisor/designee will audit daily task lists to ensure task lists are completed as assigned. Work orders will be reviewed by Maintenance Director/designee, and repairs will	

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	b. On 4/29/24 at 10:55 a.m., the bathroom shared by rooms 310 (two residents/three bed room) had a hole in the floor behind the bathroom door of 310. The bathtub and splatters of a rust colored substance and the shower curtain was dirty. The floor between the bed by the door and the middle bed there was dirty with dried food and what appeared to be spit on the floor by the wastebasket. There was dirt under the cabinets and dried liquid feeding on the floor. There was debris/dirt under the bed by the window and along the base board. There was trash, equipment, and furnishings stored behind the closet. c. On 4/29/24 at 11:06 a.m., there was a wet floor sign in the doorway of room 308 (two residents/three bed room). The privacy curtain for the bed by the door was dirty and stained. There was dirt and debris behind the closet for the second bed. In the bathroom, which was shared by room 306 (two residents/three bed room), the light was very dim and the room was dark when the door was closed. There was a missing tile, two bottles of unmarked bathing cleanser on the sink, and the baseboard by the toilet was loose. There were toilet safety rails, a pillow, and a rag stored in the bathtub. 3. 400 Hall a. On 4/29/24 at 11:18 a.m., room 408 (two residents/three bed room) had dirt and debris on the floor and at the baseboards. The privacy curtain between the door and middle bed was stained and dirty. The closet doors would not stay closed. There was a water pitcher liner sitting on the bedside dresser of the middle bed and was full (1000 milliliters) of straw colored fluid with an odor of urine. The resident was in the room and indicated it was urine and he had a urinal but		be scheduled based on importance. The Maintenance Director/designee will audit work orders and schedule any repairs/maintenance needed with a timely turnaround. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Environmental Supervisor/designee audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. Maintenance Director/designee audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. **Date systemic changes will be completed: 5/30/24**	

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	someone took it. In the bathroom, which was shared with room 410, there was dirt and debris in the corners and behind the door of 408. b. On 4/29/24 at 11:28 a.m., room 402 (three residents), identified by Housekeeper 1 as just being cleaned, had a dried substance by the dresser on the floor of the bed by the door. There was dirt, debris and cob webs in the corner and on the floor under the closet door. The privacy curtain between the door and middle bed was stained and dirty. The bathroom, which was shared with room 404 (two residents) was dirty, there were two bath basins unmarked and uncovered stored behind the toilet and there was bathing cleanser without a name on the sink. 4. 500 Hall a. On 4/29/24 at 1:58 p.m., in room 510 (two residents), there was dried liquid feeding on the feeding pump pole. An Environmental Tour was completed with the Administrator on 4/30/24 from 10:04 a.m. through 10:40 a.m. The Administrator acknowledged the above findings. A facility policy for routine cleaning of rooms, received from the Administrator as current and dated 2/9/23, indicated, routine cleaning and disinfection of frequently touched or visibly soiled surfaces would be performed in resident rooms and included feeding pump poles. The privacy curtains in the resident rooms were to be changed when visibly dirty. During an interview on 4/30/24 at 11:42 a.m., the Administrator indicated there was no policy for deep cleaning the rooms and he was unsure how			

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	often it was to be done. This citation relates to Complaints IN00429414 and IN00429590. 3.1-19(f)			
F 0925 SS=E Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, and interview, and record review, the facility failed to maintain an effective pest control program related to dead bugs/water bugs and mice droppings in the resident rooms and bathrooms for 4 of 15 rooms randomly observed. (Rooms 310, 408, 402, and 213) Findings include: During random observations, the following was observed: a. On 4/29/24 at 10:55 a.m., there were dead bugs on the floor in the corner under the cabinets in room 310. There were 2 mouse traps under the heater located under the window and there were mice droppings seen by the trap in the corner of the room by the window. b. On 4/29/24 at 11:18 a.m., there were mouse droppings in the corner behind the bed by the window in room 408. c. On 4/29/24 at 11:28 a.m., there were mouse droppings behind the bathroom door next to the bathtub in room 402 and a dead bug in the bathtub.	F 0925	It is the intention of this facility to maintain an effective pest control program. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** Floors were cleaned, and traps/glue boards were removed in rooms 210, 310, 402, and 408 and are being observed daily by housekeeping for any new sightings/signs of pests. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. Floors were cleaned, and traps/glue boards were removed in resident rooms. The Housekeeping Department will monitor rooms/floors on daily cleaning for any signs/sightings of pests. Signs/sightings will be	05/30/2024

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	d. During an observation on 4/30/24 from 10:04 a.m. to 10:40 a.m., with the Administrator present. Room 213 had glue trap for bugs on the floor by the window. there were multiple bugs in the trap. The Administrator indicated they were, "water bugs". There were mouse traps located under the heater in the room. The Administrator indicated he was not sure who checked the mice and bug traps and they should be checked when the room was cleaned. An undated facility pest control policy, received as current from the Administrator on 4/30/24 at 10:20 a.m., indicated a qualified pest control service would be contracted and the facility would maintain a report system of issues that may arise between scheduled visits of the contracted company. This citation relates to Complaints IN00429414 and IN00429590. 3.1-19(f)(4)		reported to the Maintenance Director/designee immediately to begin a pest control program for that area. If required, vendor will be contacted to initiate a pest treatment program. A log will be kept of areas that a pest control program is in place, Maintenace Director/designee will monitor areas where a pest control program is in place a minimum of 3 times per week for effectiveness or determined that there are no further pests. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff have been educated in how to report any sightings/signs of pests throughout the facility. The Maintenance Director/designee will put a control program in place for any areas identified as having any signs/sighting from these reports and initiate a program and a log of that area to monitor for effectiveness of the applied program. Maintenace Director/designee will provide a summary of any pest programs in place in morning meeting. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Environmental	

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			Supervisor/designee will complete audits on 10 random rooms weekly to ensure pest sightings are reported. Maintenance Director/designee will log areas noted for having pest signs/sightings, interventions in place and effectiveness. Audits will be completed daily x5, weekly x4 weeks, bi-monthly for 2 months, monthly x6, and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **Date systemic changes will be completed: 5/30/24**	