STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00442992. This visit included a State Residential Licensure Survey. Complaint IN00442992 - State deficiencies related to the allegations are cited at F9999. Survey dates: September 16, 17, 18, 19, 20 and 23, 2024 Facility number: 000471 Provider number: 155572 AIM number: 100290390 Census Bed Type: SNF/NF: 78 SNF: 4 Residential: 5 Total: 87 Census Payor Type: Medicare: 2 Medicaid: 35 Other: 45 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/30/24.	F 0000		
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, record review, and interview, the facility failed to ensure residents	F 0554	**Tag number: F554 Med Self Admin**	11/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deana Jordan Collins	Regional Nurse Consultant	10/29/2024

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	were assessed for self-administration of medications and had a Physician's Order to self-administer medications, for 2 of 2 residents reviewed for self-administration of medication. (Residents 9 and 32) Findings include: 1. During a medication pass observation on 9/19/24 at 11:12 a.m., LPN 1 was observed preparing Resident 9's medications. The nurse indicated the resident was to have a nebulizer breathing treatment. She poured a plastic vial of ipratropium-albuterol (medication to help control the symptoms of lung disease) 3 ml (milliliters) into a medicine cup attached to an oxygen mask. She then placed the oxygen mask over the resident's face, turned on the treatment machine, and told the resident to take a few deep breaths. She then told the resident she would be back in to remove the breathing treatment in about 10 minutes. The LPN then proceeded to leave the room and walked back to the medication cart to prepare the next resident's medication. The LPN was not observed checking the resident's oxygen saturation or lung sounds prior to administering the nebulizer treatment. During an interview after leaving the resident's room, the LPN indicated she did not check his oxygen saturation or lung sounds. She was unaware if the resident had a self-administration assessment completed. She further indicated she did not normally stay in the resident's rooms while they were receiving the breathing treatments. Record review for Resident 9 was completed on 9/19/24 at 11:40 a.m. Diagnosis included, but were not limited to, hypertension, anxiety, and dyspnea (shortness of breath).		I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 9 had a medication self-administration completed on 9/25/24. Resident 32 had no adverse reactions related to the alleged deficient practice. II. 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 the alleged deficient practice. A full house audit was completed to ensure any resident who self-administers meds had a timely medication self-administration assessment completed. LPN 1 was educated on the policy for medication self-administration. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nurses on the policy “Medication Administration General Guidelines.” To include medication self-administration assessments IV. 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 all new admissions/re-admission to	

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	The record lacked any indication there was a Physician's Order or a medication self-administration assessment completed for the resident to self administer his breathing treatment without supervision. During an interview on 9/19/24 at 11:44 a.m., the Regional Vice President of Operations indicated the residents were not to be left alone during a breathing treatment unless they had a Physician's Order and a self-administration assessment completed. A policy titled, "Nebulizer-Medication Administration", and received as current from the facility on 9/19/24, indicated, "...4. Obtain baseline pulse, respiratory rate and lung sounds..." "...12. Remain with resident for the treatment unless the resident has been assessed and authorized to self-administer..."2. On 9/17/24 at 10:49 a.m., Resident 32 was observed walking out of her bathroom, to her bed. There was a medication cup on her dresser that contained 4 pills. One bottle of saline nasal spray and one bottle of Fluticasone Propionate Suspension (a nasal spray for allergies), both labeled with Resident 32's name, were observed on her bathroom counter. The resident indicated the nurse left the pills for her that morning and that she administered her own nasal sprays. Resident 32's record was reviewed on 9/17/24 at 1:18 p.m. Diagnoses included, but were not limited to, obsessive-compulsive disorder, hypothyroidism, and allergic rhinitis. An Annual Minimum Data Set (MDS) assessment, dated 7/10/24, indicated the resident was cognitively intact.		ensure any resident who is able to self-administer meds has an assessment completed. Audits will be completed 5x week x 4 weeks, 2x week x 4 weeks, then weekly x 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	

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	An Interdisciplinary Team (IDT) note, dated 12/4/2023, indicated the IDT met to review the resident and determined the resident was able to self-administer supplements and eye drops. The Physician's Orders indicated the resident may self-administer supplements, eye drops, saline nasal spray. There were no orders for self-administration of prescribed oral medications or Fluticasone Propionate Suspension. During an interview on 9/17/24 at 10:52 a.m., LPN 2 indicated she left 4 pills in a medication cup on the residents' dresser around 8:00 a.m. because she was told the resident could take them herself. The medications were krill oil, Levothyroxine (a thyroid medication), fluvoxamine maleate (a medication for obsessive-compulsive disorder), and Advil (Ibuprofen). During an interview on 9/19/24 1:31 p.m., the Regional VP of Operations indicated the assessment to self-administer should be done every 6 months, and the medications should not be left at the bedside, but he would check the policy. A policy titled, "Medication Administration General Guidelines", and received as current from the facility on 9/19/24, indicated, " ...12. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications ..." " ...16. The resident is always observed after administration to ensure was completely ingested. If only a partial dose is ingested, this noted on the MAR, and action is taken as appropriate ..."			

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F 0610 SS=D Bldg. 00	3.1-11(a) 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation Based on record review and interview, the facility failed to ensure a resident involved in a physical altercation with another resident received psychosocial follow up care for 1 of 3 residents reviewed for abuse. (Resident 136) Finding includes: The closed record for Resident 136 was reviewed on 9/19/24 at 9:30 a.m. The resident was admitted to the facility on 8/23/24 and discharged to home on 9/8/24. Diagnoses included, but were not limited to, unspecified dementia, hypertension and depression. He resided on the locked memory care unit. The Admission Minimum Data Set assessment, dated 8/29/24, indicated the resident had severe cognitive impairment. An IDOH (Indiana Department of Health) Facility Reported Incident, dated 9/5/24, indicated another resident had approached Resident 136 and struck him numerous times. The residents were immediately separated and assessed for injuries. The other resident was sent to the hospital for aggressive behaviors to be evaluated, and Resident 136 was to be monitored for signs of psychosocial distress. There was no documentation the resident had been monitored for psychosocial distress following the incident. The resident was discharged to home on 9/8/24.	F 0610	**Tag number: F610 Investigate/Prevent/Correct Violation** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 136 was discharged from the facility on 9/8/24 II. 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 the alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator/designee to educate SSD on completing psychosocial assessments after an altercation with another resident IV. 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; Administrator/designee will audit for a psychosocial assessment being completed after an allegation of an altercation. Audits will be completed 5x week x 4	11/01/2024

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	During an interview on 9/19/24 at 10:37 a.m., the Social Service Director indicated residents were normally monitored for 72 hours after an altercation for psychosocial distress. For some reason, this event had not been triggered and he was not monitored after the altercation. The current "Abuse Prevention and Reporting" policy was reviewed and did not have specific guidelines for monitoring psychosocial distress. 3.1-28(d)		weeks, 2x week x 4 weeks then weekly x 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on record review and interview, the facility failed to ensure a resident and/or their Responsible Party were notified in writing related to a transfer to the hospital for 1 of 3 residents reviewed for hospitalization. (Resident 27) Finding includes: Resident 27's record was reviewed on 9/18/24 at 3:01 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and elevation of levels of liver transaminase levels (liver enzymes). The Quarterly Minimum Data Set (MDS) assessment, dated 7/23/24, indicated the resident was moderately impaired for daily decision making. A Nurses' Note, dated 7/12/24 at 6:47 p.m., indicated the Physician was in to see the resident and new orders to send the resident to the hospital were obtained due to elevated liver enzymes. The Responsible Party was notified and	F 0623	**Tag number: F623** **Transfer/Discharge** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 27 had no adverse outcomes related to the alleged deficient practice. II. 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 resident have the potential to be affected by the alleged deficient practice. Moving forward family/RP will be notified of all resident transfers to hospital III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nursing	11/01/2024

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	report was called to the hospital. The resident was sent with appropriate paperwork. A Physician Order Note, dated 7/12/24 at 6:48 p.m., indicated the resident was seen due to elevated liver enzymes. The resident indicated he had nausea and emesis, but he did not inform staff. He had epigastric (upper abdomen) pain with palpation (touch). The resident was sent to the hospital. There was no documentation to indicate the State approved transfer form was completed and sent with the resident. There was no documentation to indicate the resident's Responsible Party had received written notification of the resident's transfer to the hospital. During an interview on 9/19/24 at 9:42 a.m., the Regional Vice President of Operations indicated there was no documentation related to the State transfer form being sent with the resident or to the resident's Responsible Party. A policy titled, "Notice of Transfer and Discharge" indicated "...Prior to discharge or transfer, the facility will: 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 will send a copy of the notice to a representative of the Office of the State Long-term Care Ombudsman..." 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii)		staff on notifying family/RP on any resident being transferred to the hospital IV. 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 hospital discharges to ensure family/RP notifications were made. Audits will be completed weekly x 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	

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F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on record review and interview, the facility failed to ensure a resident and/or their Responsible Party were sent the facility's bed-hold and reserve bed payment policy before and upon transfer to the hospital for 1 of 3 residents reviewed for hospitalization. (Resident 27) Finding includes: Resident 27's record was reviewed on 9/18/24 at 3:01 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and elevation of levels of liver transaminase levels (liver enzymes). The Quarterly Minimum Data Set (MDS) assessment, dated 7/23/24, indicated the resident was moderately impaired for daily decision making. A Nurses' Note, dated 7/12/24 at 6:47 p.m., indicated the Physician was in to see the resident and new orders to send the resident to the hospital were obtained due to elevated liver enzymes. The Responsible Party was notified and report was called to the hospital. The resident was sent with appropriate paperwork. A Physician Order Note, dated 7/12/24 at 6:48 p.m., indicated the resident was seen due to elevated liver enzymes. The resident indicated he had nausea and emesis, but he did not inform staff. He had epigastric (upper abdomen) pain with palpation (touch). The resident was sent to the hospital. There was no documentation to indicate the	F 0625	**Tag number: F625 Bed Hold** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Bed hold policy was sent to RP and given to resident 27 on 10/10/24 II. 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 the alleged deficient practice. Moving forward any resident who is discharged to the hospital will be given a copy of the bed hold policy III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator/designee to educate SSD on when to provide a bed hold policy. IV. 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; Administrator/designee will audit discharges to ensure a bed hold policy was provided when applicable. Audits will be completed weekly x 6 months. The results of these audits will be reviewed in Quality Assurance	11/01/2024

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	facility's bed-hold policy was sent to the resident and/or their Responsible Party. During an interview on 9/19/24 at 9:42 a.m., the Regional Vice President of Operations indicated there was no documentation related to the bed-hold policy being sent to the resident and/or their Responsible Party. 3.1-12(a)(25)(A)		Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments Based on observation, record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessments were accurately completed related to restraint use for 1 of 25 MDS assessments reviewed. (Resident 29) Finding includes: Resident 29 was observed in bed on 9/16/24 at 10:53 a.m. At the time, he indicated he did not need assistance with anything, including getting up into a chair. He did not use any type of restraint device to help hold him in place. There were no restraints noted in his bed or in any wheelchairs or chairs in the room. Resident 29's record was reviewed on 9/19/24 at 2:35 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance and vascular dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 8/22/24, indicated the resident was cognitively intact for daily decision making. He used a physical trunk restraint while in the	F 0641	**Tag number: F641 Accuracy of Assessments** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 29's MDS was modified on 9/23/24 II. 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 the alleged deficient practice. A full house audit was completed to ensure residents restraint MDS was coded correctly III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; MDS coordinator educated on ensuring proper coding of restraints on an MDS. IV. How the corrective action(s) will be monitored to ensure the	11/01/2024

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	chair or out of bed less than daily. He required supervision or touching assist with all activities of daily living (ADLs), including, but not limited to, transfers, toileting hygiene, oral hygiene, showers/bathing, and eating. During an interview on 9/20/24 at 10:20 a.m., the MDS Coordinator indicated that the restraints were coded in error and she would submit a modification to the MDS immediately. 3.1-31(i)		deficient practice will not recur i.e., what quality assurance program will be put into place; MDS/designee to audit residents MDS's to ensure accurate coding Audits will be completed on 5 residents MDS's a week x 8 weeks, then 1 residents MDS assessment weekly x 4 months The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure a resident with abnormal lab results received timely intervention for 1 of 3 residents reviewed for hospitalization (Resident 68), medications were given as ordered for 2 of 5 residents reviewed for unnecessary medications (Residents 24 and 55), and skin discolorations were assessed and monitored for 1 of 2 residents reviewed for non-pressure skin conditions. (Resident 37) Findings include: 1. On 9/18/24 at 9:31 a.m., Resident 68 was observed lying in bed with his eyes closed.	F 0684	**Tag number: F684 QOC** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 68 no longer resides at the facility. The physician was notified of resident 24's medication not being held per physician's order and resident 55's medications not given or held per physicians orders. An order to monitor skin discoloration until healed was entered for resident 37 on 9/19/24 II. How other residents having the	11/01/2024

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	Normal Saline 0.9% intravenous fluids were infusing at 100 ml (milliliters) per hour to his left upper arm PICC (peripherally inserted central catheter, intravenous access) line. The record for Resident 68 was reviewed on 9/18/24 at 9:43 a.m. Diagnoses included, but were not limited to, cerebral infarction, chronic kidney disease, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 8/30/24, indicated the resident was cognitively impaired. The resident was hospitalized on 7/2/24 and returned to the facility on 7/15/24. The resident was again hospitalized on 8/16/24 and returned to the facility on 8/24/24. A Care Plan, updated 3/4/24, indicated the resident was at risk for decreased cardiac output related to atrial fibrillation, hyperlipidemia, and hypertension. An intervention, dated 3/4/24, indicated to monitor lab values and report results to the Physician. A Care Plan, updated 3/4/24, indicated the resident was at risk for dehydration related to diuretic use. An intervention, dated 3/26/24, indicated to obtain labs and diagnostics as ordered and follow up with Physician as indicated. A Nurse Practitioner Note, dated 6/28/24 at 1:34 p.m., indicated the resident was seen for evaluation due to reported delusions, headaches, vomiting, and weight loss. The assessment indicated chronic kidney disease and sub-acute cholecystitis. Some lab tests and a KUB (x-ray of the kidney, ureter, bladder) were ordered for 6/28/24 and repeat lab tests were ordered for 7/1/24.		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 the alleged deficient practice. Physician to review any resident with medications with b/p parameters to ensure they are accurate. A full house skin sweep was completed to ensure there were no other skin concerns not addressed. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nursing staff on administering medications per phsycians orders to include holding medications not within parameters. Nursing staff also educated on identifying and monitoring any areas of skin discoloration. IV. 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 residents MARS to ensure medications are passed and/or held per physicians orders. DON/designee will audit weekly skin assessments to ensure any areas of discoloration are monitored per policy. Audtis will be completed on 5 residents a week x 8 weeks, then 1 resident a week x 4 months.	

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	155572	A. BUILDING 00 B. WING	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

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	A Progress Note, dated 6/28/24 at 3:54 p.m., indicated the KUB results and lab results were reported to the Nurse Practitioner. The lab results indicated the following tests were collected on 7/1/24 at 7:09 a.m. and reported on 7/1/24 at 7:59 p.m.: comprehensive metabolic panel (electrolytes), PT/INR (prothrombin time, blood clotting test), TSH (thyroid stimulating hormone), CBC (complete blood count), lipid panel (cholesterol and triglycerides), vitamin D 25-OH, folate, vitamin B12, and hemoglobin A1C (blood sugar levels). There was a lack of any documentation the lab results from 7/1/24 had been communicated with the Physician or Nurse Practitioner. A Nurse Practitioner Note, dated 7/2/24 at 3:26 p.m., indicated she had reviewed the 7/1/24 lab results. The BUN (blood urea nitrogen, a kidney function lab test) was 69 (elevated), the creatinine (a kidney function lab test) was 3.3 (elevated), the potassium was 5.6 (elevated), the alkaline phosphatase (a liver function lab test) was 800 (elevated), and the white blood cell count was 12 (elevated). She had spoken with the Nurse Practitioner who had been on call 7/1/24 and she had not been made aware of these lab results. The resident was to be sent out to the Emergency Room (ER) for renal failure. A Progress Note, dated 7/2/24 at 3:29 p.m., indicated the Nurse Practitioner had ordered to send the resident to the ER for abnormal labs. A Progress Note, dated 7/2/24 at 3:30 p.m., indicated 911 had been called to transport the resident to the ER.		The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	

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	A Progress Note, dated 7/2/24 at 3:47 p.m., indicated EMS (Emergency Medical Services) was at the facility and the resident was going to the ER for evaluation and treatment. The hospital Admission History and Physical, dated 7/2/24, indicated the resident was admitted for acute kidney injury. The chief complaint indicated acute renal failure and electrolyte abnormalities were found on follow up labs. Hyperkalemia (high potassium) and hyponatremia (low sodium) were mild and improved with IV (intravenous) hydration and the renal function was also improving. During an interview on 9/18/24 at 10:50 a.m., the Regional Vice President of Operations indicated he would look into the situation. No further information was provided. 2. Resident 24's record was reviewed on 9/18/24 at 9:33 a.m. Diagnoses included, but were not limited to, dementia and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 8/13/24, indicated the resident was cognitively intact. A Care Plan, dated 3/14/22, indicated the resident			

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	was at risk for decreased cardiac output related to hypertension (high blood pressure). Interventions included, but were not limited to, administer medications as ordered. A Physician's Order, dated 5/18/24, indicated lisinopril 20 milligram (mg) tablet once daily. A Physician's Order, dated 5/18/24, indicated amlodipine besylate 5 mg tablet once daily. A Physician's Order, dated 5/18/24, indicated hold lisinopril and amlodipine if systolic blood pressure (top number) is less than 110 every shift for hypotension. The August and September 2024 Medication Administration Record indicated the lisinopril and amlodipine were not held per the Physician's Order on the following dates and times: - 8/7/24 at 7:00 a.m., blood pressure 106/68 - 8/11/24 at 7:00 a.m., blood pressure 109/71 - 8/16/24 at 7:00 a.m., the medication was not administered and a blood pressure was not documented - 9/13/24 at 7:00 a.m., the medication was not administered and a blood pressure was not documented During an interview on 9/19/24 at 9:42 a.m., the Regional Vice President of Operations indicated he had no further information to provide. 3. Resident 55's record was reviewed on 9/18/24 at 11:51 a.m. Diagnoses included, but were not limited to, hypertension, chronic kidney disease, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS)			

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	assessment, dated 8/26/24, indicated the resident was cognitively intact for daily decision making. The current Care Plans, indicated the resident had hyperlipidemia, hypertension, and received hemodialysis three times per week. A Care Plan, dated 5/7/24, indicated the resident was at risk for decreased cardiac output related to hyperlipidemia, hypertension, and hypotension. Interventions included, but were not limited to, administer medications as ordered. The September 2024 Physician Order Summary indicated the resident received gabapentin 100 milligrams (mg) 1 capsule three times a day, midodrine 10 mg tablet three times a day, and sevelamer carbonate 800 mg 2 tablets with meals. The August and September 2024 Medication Administration Record (MAR) indicated the medications were not administered as ordered on the following dates and times: Midodrine: - 8:00 a.m. on 8/2, 8/5, 8/6, 8/10, 8/11, 8/16, 8/25, and 9/5/24 - 12:00 p.m. on 8/1, 8/3, 8/5, 8/6, 8/8, 8/10, 8/12, 8/13, 8/15, 8/16, 8/17, 8/23, 8/24, 8/27, 8/29, 8/31, 9/3, 9/5, 9/7, 9/8, 9/10, 9/12, 9/14, 9/17, and 9/19/24 - 4:00 p.m. on 8/5, 8/10, 8/17, and 8/19/24 - 6:00 p.m. on 8/22, 8/23, 8/25, 9/2, 9/5, 9/8, and 9/9/24 Gabapentin: - 8:00 a.m. on 8/21/24 - 12:00 p.m. on 8/1, 8/3, 8/6, 8/8, 8/10, 8/13, 8/15, 8/17, 8/20, 8/21, 8/24, 8/27, 8/29, 8/31, 9/3, 9/5, 9/7, 9/10, 9/12, 9/14, 9/17, and 9/19/24 - 8:00 p.m. on 9/9/24			

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Sevelamer carbonate:
- 12:00 p.m. on on 8/1, 8/3, 8/6, 8/8, 8/10, 8/13, 8/15, 8/17, 8/24, 8/27, 8/29, 8/31, 9/3, 9/5, 9/7, 9/10, 9/12, 9/14, 9/17, and 9/19/24

A Physician's Order, dated 8/21/24, indicated midodrine 10 mg tablet three times a day, hold if systolic blood pressure (top number) is above 130.

The August and September 2024 Medication Administration Record (MAR) indicated the midodrine was not held as ordered on the following dates and times:
- 8/22/24 at 9:00 a.m., blood pressure 134/60
- 8/22/24 at 12:00 p.m., blood pressure 150/76
- 8/28/24 at 9:00 a.m., blood pressure 142/80
- 8/28/24 at 6:00 p.m., blood pressure 167/93
- 9/1/24 at 9:00 a.m., blood pressure 144/78
- 9/10/24 at 6:00 p.m., blood pressure 138/71
- 9/12/24 at 6:00 p.m., blood pressure 141/86

During an interview on 9/19/24 at 9:42 a.m., the Regional Vice President of Operations indicated he had no further information to provide.

4. During an observation and interview on 9/16/24 at 2:51 p.m., Resident 37 indicated she had gone to the hospital and they tried to put multiple intravenous lines into both arms, but they were not successful. The resident's bilateral forearms were observed with large discolorations.

Resident 37's record was reviewed on 9/17/24 at 2:48 p.m. Diagnoses included, but were not limited to, hemiplegia (weakness) affecting the left nondominant side and major depressive disorder with psychotic features.

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	The Quarterly Minimum Data Set (MDS) assessment, dated 8/20/24, indicated the resident was cognitively intact for daily decision making. A Weekly Skin Observation assessment, dated 9/11/24 at 8:03 a.m., indicated the general skin observation was warm, dry (normal) with no foot concerns. There were no skin problems. A Weekly Skin Observation assessment, dated 9/18/24 at 2:10 p.m., indicated the general skin observation was warm, dry (normal) with no foot concerns. There were no skin problems. During an interview on 9/19/24 at 9:42 a.m., the Regional Vice President of Operations indicated there was no documentation of the bruising in the resident's record and the staff had now implemented a new order for monitoring of the bilateral forearm bruising. A policy titled, "Skin Condition Assessment & Monitoring - Pressure and Non-Pressure," indicated "...Non-pressure skin conditions (bruises/contusions...etc.) will be assessed for healing progress and signs of complications or infection weekly...A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse." 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision Based on observation, record review, and interview, the facility failed to ensure a resident received ancillary services to maintain vision and hearing in a timely manner, for 1 of 1 residents	F 0685	**Tag number: F685** **Tx/Devices/Vision/Hearing** I. What corrective action(s) will be accomplished for those residents	11/01/2024

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	reviewed for vision/hearing. (Resident 27) Finding includes: During an interview on 9/16/24 at 10:43 a.m., Resident 27 indicated he could not hear or see and required outside services, however, the facility had not done anything to help him with hearing or vision services at the time. Resident 27's record was reviewed on 9/18/24 at 3:01 p.m. Diagnoses included, but were not limited to, encephalopathy (brain disease), legal blindness, and hearing loss. The Quarterly Minimum Data Set (MDS) assessment, dated 7/23/24, indicated the resident was moderately impaired for daily decision making. He had moderate difficulty with the ability to hear and did not have hearing aids. He had highly impaired vision and did not have corrective lenses. A Care Plan, dated 3/25/24, indicated the resident had a behavior problem related to being hard of hearing and yelling out and speaking loudly. A Care Plan, dated 2/20/24, indicated the resident had impaired communication related to hearing deficits. A Physician's Order, dated 7/26/24, indicated to add the resident to the eye doctor list for the next rounds, as he requested an evaluation. An Ancillary Services Consent for vision, hearing, and podiatry services, dated 2/19/24, had verbal consent written for all services. During an interview on 9/18/24 at 3:11 p.m., the		found to have been affected by the deficient practice; Resident 27 has an appt scheduled to see the optometrist on 111/5/24 and audiologist on 10/23/24 II. 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 the alleged deficient practice. A full house audit was completed to ensure any resident who consented to optometry or audiology was seen in a timely manner or an appt was scheduled. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; SSD educated on scheduling an appt for any resident who consented to seeing optometry or audiology in a timely manner. IV. 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; SSD/designee will complete an audit on all new admission/readmissions to ensure anyone consenting to audiology or optometry has an appointment scheduled in a timely manner. Audits will be conducted 5x week x 4 weeks, then weekly x 5 months.	

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	Social Services Director (SSD) indicated the resident and/or the Responsible Party had given verbal consent for the three ancillary services, however the Ancillary Service Company indicated they needed a signed consent and order to treat. Ancillary Service Company would not accept a verbal consent to treat. The SSD indicated the current list for the ancillary services did not include Resident 27 at this time for both audiology and optometry services. The SSD assessed needs for services on a quarterly basis and would address this with the resident and/or their Responsible Party at the next Care Plan Meeting. During an interview on 9/19/24 at 1:30 p.m., the Regional Vice President of Operations indicated the current process for ancillary services to come in and treat the residents started in March of 2024 and the facility staff had just sent off a new consent to treat with ancillary services. A policy titled, "Policy on On-site Health Care Services," indicated "...It is the policy of the facility to assist resident sin arranging health services on site as needed per resident request. Facility will make appointments for ancillary services as requested by resident. On-site services available: ...b) audiologist c) optometry..." 3.1-39(a)(1)		The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to ensure fall precautions were in place for a resident with a history of falls for 1 of 7 residents reviewed for accidents. (Resident 21)	F 0689	**Tag number: F689 Free of Accidents** I. What corrective action(s) will be accomplished for those residents found to have been affected by the	11/01/2024

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	Finding includes: On 9/16/24 at 10:23 a.m., Resident 21 was observed seated in her wheelchair near the front Nurse's Station. Observation of her room at that time, indicated there were no non-skid strips to the floor anywhere in her room or bathroom. On 9/18/24 at 9:27 a.m., Resident 21 was assisted by staff to her room and was seated in her wheelchair. There were no non-skid strips observed to the floor anywhere in her room or bathroom. The record for Resident 21 was reviewed on 9/19/24 at 11:05 a.m. Diagnoses included, but were not limited to, dementia with psychotic disturbance, chronic obstructive pulmonary disease, and anxiety disorder. The Quarterly MDS (Minimum Data Set) assessment, dated 8/15/24, indicated the resident was cognitively impaired. She had one fall with major injury and one fall with no injury since the prior assessment. A Care Plan, updated 10/23/23, indicated the resident had a potential for falls. An intervention, dated 7/22/24, indicated non-skid strips in front of the bed and in the bathroom. An Indiana Department of Health reportable incident, dated 7/20/24, indicated the resident was found on the floor in the bathroom. The resident indicated she had spilled her drink while attempting to go to the bathroom and slipped in the liquid. She complained of right shoulder pain and was sent to the hospital for evaluation. She was found to have an anterior displaced fracture		deficient practice; Resident 21 had her nonskid strips placed in room II. 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 the alleged deficient practice. A full house audit was completed to ensure all fall interventions were in place and any discrepancies corrected. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nursing staff on ensuring fall interventions are in place. IV. 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 conduct a fall intervention audit as follows: Audits will be completed on 10 residents at risk for falls a week for 8 weeks, then 2 residents a week x 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the	

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	of sternal end of right clavicle. A Fall IDT (interdisciplinary team) Note, dated 7/22/24 at 10:18 a.m., indicated the resident had attempted to transfer herself to the toilet and slipped in iced tea that she had spilled on the floor. The suggested new intervention was to place non-skid strips in front of the bed and toilet and place lids on all cups. During an interview on 9/18/24 at 10:50 a.m., the Regional Vice President of Operations indicated he would review the fall interventions. A facility policy, titled "Fall Prevention Program," indicated, "...Safety interventions will be implemented for each resident identified at risk...Accident/Incident reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determine possible safety interventions..." 3.1-45(a)		plan of correction as indicated. Date of compliance: 11/1/24	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review and interview, the facility failed to ensure a resident received the necessary care and treatment related to oxygen not administered as ordered or monitored for 1 of 1 residents reviewed for respiratory care. (Resident 7) Finding includes: On 9/17/24 at 9:44 a.m., Resident 7 was observed seated in her recliner. There was an oxygen concentrator next to her that was turned on. The	F 0695	**Tag number: F695** **Resp/Trach/Suctioning** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 7's oxygen order was changed to PRN on 10/8/24 II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	11/01/2024

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	oxygen tubing and nasal cannula were lying on the floor. The resident indicated she only used the oxygen at night. On 9/18/24 at 11:53 a.m. the resident was observed seated in her room. The oxygen concentrator was off and the oxygen tubing was in a plastic bag. The resident's record was reviewed on 9/18/24 at 10:25 a.m. Diagnoses included, but were not limited to, acute and chronic respiratory failure, diabetes mellitus, schizoaffective disorder and depression. The Quarterly Minimum Data Set assessment, dated 8/15/24, indicated the resident had moderate cognitive deficits, required substantial assistance for transfers and moderate assistance for bed mobility. A Physician's Order, dated 8/31/24, indicted to administer oxygen at 3 liters per minute continuously per nasal cannula. The September 2024 Medication Administration Record (MAR) did not have any documentation related to oxygen being administered or refused. During an interview on 9/18/24 at 2:01 p.m., LPN 1 indicated the resident would refuse to use her oxygen and it was only ordered as needed. She was not aware the order was for continuous oxygen. There was no place on the MAR to document if the oxygen was refused or in use. 3.1-47(a)(6)		action(s) will be taken; Any resident on oxygen therapy has to potential to be affected by the alleged deficient practice. A full house audit was conducted on any resident on oxygen therapy to ensure their orders are accurate. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nursing staff on following a physicians order for oxygen therapy. IV. 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 to complete an audit on residents who are on oxygen therapy to ensure it is being utilized per physicians orders. Audits will be completed on 5 residents a week x 4 weeks, 2 residents a week x 4 weeks then 1 resident a week x 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	

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	155572	A. BUILDING 00 B. WING	09/23/2024

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F 0698 SS=D Bldg. 00	483.25(l) Dialysis Based on observation, record review, and interview, the facility failed to provide the necessary care and services for residents who received hemodialysis, related to not monitoring the dialysis access site, for 1 of 1 resident reviewed for dialysis. (Resident 231) Finding includes: On 9/16/24 at 10:19 a.m., Resident 231 was seated in his wheelchair near the front Nurse's Station. He had his dialysis bag on his lap and indicated he was waiting to leave for dialysis. He went to dialysis on Mondays, Wednesdays, and Fridays. He had a catheter to his right chest that was used for dialysis. The record for Resident 231 was reviewed on 9/19/24 at 11:05 a.m. Diagnoses included, but were not limited to, end stage renal disease, hypertension, and type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 7/10/24, indicated the resident was cognitively intact and received hemodialysis services. The resident was hospitalized on 9/2/24 and readmitted to the facility on 9/13/24. The Physician's Order Summary, dated 9/2024, indicated there were no current orders for when/where the resident was receiving dialysis or for monitoring of the dialysis catheter. There were previous orders, discontinued on 9/3/24, for dialysis services and dialysis catheter monitoring. These orders had not been continued upon	F 0698	**Tag number: F698 Dialysis** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 231 had an order to monitor his dialysis site entered on 10/4/24 II. 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; Any resident with a dialysis catheter has the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure any resident with a dialysis catheter has an order to monitor site. Any discrepancies were immediately corrected. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nursing staff on the policy “Dialysis Monitoring and Observation” to include monitoring a dialysis catheter. IV. 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 new admissions/re-admissions or any resident who has a dialysis	11/01/2024

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	readmission on 9/13/24. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 9/2024, lacked any monitoring of the dialysis catheter for 9/13/24, 9/14/24, 9/15/24, 9/16/24, and 9/17/24. During an interview on 9/18/24 at 10:50 a.m., the Regional Vice President of Operations indicated he would review the dialysis orders. A Facility Policy, titled "Dialysis Monitoring and Observation," received as current, indicated, "...7. If the resident has a catheter for dialysis the nurse will assess the catheter site for any signs of drainage and condition of the dressing to the site every shift...Documentation:...3. Assessment of dialysis catheter site for any signs of drainage and condition of the dressing to the site every shift..." 3.1-37(a)		catheter placed to ensure there is an order to monitor catheter site. Audits will be completed 5x week x 4 weeks, 2x week x 4 weeks, then weekly x 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to ensure medications were properly stored for 2 of 4 medication carts observed. (ACU Cart, and West 1 Cart) Findings include: 1. On 9/20/24 at 2:33 p.m., the ACU Medication Cart was observed with Agency QMA 1. There were multiple pills of different sizes and colors that were loose and out of the packages throughout the bottoms of the drawers in the cart. The QMA indicated that was the first day she had worked on the cart.	F 0761	**Tag number: F761 Label/Store Drugs** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the alleged deficient practice. II. 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; A full house audit was completed on all	11/01/2024

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	2. On 9/20/24 at 2:47 p.m., the West 1 Medication Cart was observed with RN 2. There were multiple pills of different sizes and colors that were loose and out of the packages throughout the bottoms of the drawers in the cart. The RN indicated that nursing was responsible to clean the carts. During an interview on 9/20/24 at 2:45 p.m., the Assistant Director of Nursing indicated the Director of Nursing was usually responsible to make sure the carts were cleaned. 3.1-25(j) 3.1-25(o)		medication carts to ensure they are free from loose medications. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nursing staff on ensuring medication carts don't have loose pills/free of debris. IV. 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 to audit medication carts to ensure they are free from loose medications/debris. Audits will be completed weekly x 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results Based on observation, record review, and interview, the facility failed to ensure abnormal lab results were reported to the Physician for 1 of 3 residents reviewed for hospitalization (Resident 68).	F 0773	**Tag number: F773** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The provider	11/01/2024

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	Finding includes: On 9/18/24 at 9:31 a.m., Resident 68 was observed lying in bed with his eyes closed. Normal Saline 0.9% intravenous fluids were infusing at 100 ml (milliliters) per hour to his left upper arm PICC (peripherally inserted central catheter, intravenous access) line. The record for Resident 68 was reviewed on 9/18/24 at 9:43 a.m. Diagnoses included, but were not limited to, cerebral infarction, chronic kidney disease, and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 8/30/24, indicated the resident was cognitively impaired. The resident was hospitalized 7/2/24 and returned to the facility on 7/15/24. The resident was again hospitalized on 8/16/24 and returned to the facility on 8/24/24. A Care Plan, updated 3/4/24, indicated the resident was at risk for decreased cardiac output related to atrial fibrillation, hyperlipidemia, and hypertension. An intervention, dated 3/4/24, indicated to monitor lab values and report results to the Physician. A Care Plan, updated 3/4/24, indicated the resident was at risk for dehydration related to diuretic use. An intervention, dated 3/26/24, indicated to obtain labs and diagnostics as ordered and follow up with Physician as indicated. A Nurse Practitioner Note, dated 6/28/24 at 1:34 p.m., indicated the resident was seen for evaluation due to reported delusions, headaches, vomiting, and weight loss. The assessment indicated chronic kidney disease and sub-acute		was notified of the residents abnormal lab values. II. 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 the alleged deficient practice. Moving forward, the provider will be notified timely of any abnormal lab III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nurses on timely notification to the provider of any abnormal labs IV. 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 lab results to ensure any abnormal labs were reported to the provider timely Audits will be completed 5xweek x 4 weeks, 2x week x 4 weeks then weekly x 4 weeks. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	cholecystitis. Some labs and a KUB (x-ray of the kidney, ureter, bladder) were ordered for 6/28/24 and repeat labs were ordered for 7/1/24. A Progress Note, dated 6/28/24 at 3:54 p.m., indicated the KUB results and lab results were reported to the Nurse Practitioner. The lab results indicated the following labs tests were collected on 7/1/24 at 7:09 a.m. and reported on 7/1/24 at 7:59 p.m.: comprehensive metabolic panel (electrolytes), PT/INR (prothrombin time, blood clotting test), TSH (thyroid stimulating hormone), CBC (complete blood count), lipid panel (cholesterol and triglycerides), vitamin D 25-OH, folate, vitamin B12, and hemoglobin A1C (blood sugar levels). There was lack of any documentation the lab results from 7/1/24 had been communicated with the Physician or Nurse Practitioner. A Nurse Practitioner Note, dated 7/2/24 at 3:26 p.m., indicated she had reviewed the 7/1/24 lab results. The BUN (blood urea nitrogen, a kidney function lab test) was 69 (elevated), the creatinine (a kidney function lab test) was 3.3 (elevated), the potassium was 5.6 (elevated), the alkaline phosphatase (a liver function lab test) was 800 (elevated), and the white blood cell count was 12 (elevated). She had spoken with the Nurse Practitioner who had been on call 7/1/24 and she had not been made aware of these lab results. The resident was to be sent out to the Emergency Room (ER) for renal failure. A Progress Note, dated 7/2/24 at 3:29 p.m., indicated the Nurse Practitioner had ordered to send the resident to the ER for abnormal labs.		Date of compliance: 11/1/24	

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	A Progress Note, dated 7/2/24 at 3:30 p.m., indicated 911 had been called to transport the resident to the ER. A Progress Note, dated 7/2/24 at 3:47 p.m., indicated EMS (Emergency Medical Services) was at the facility and the resident was going to the ER for evaluation and treatment. The hospital Admission History and Physical, dated 7/2/24, indicated the resident was admitted for acute kidney injury. The chief complaint indicated acute renal failure and electrolyte abnormalities were found on follow up labs. Hyperkalemia (high potassium) and hyponatremia (low sodium) were mild and improved with IV (intravenous) hydration and the renal function was also improving. During an interview on 9/18/24 at 10:50 a.m., the Regional Vice President of Operations indicated he would look into the situation. No further information was provided. A Facility Policy, titled "Physician-Family Notification-Change in Condition," received as current, indicated, "...The facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse practitioner; and if known, notify the resident's legal representative or an interested family member when there is:...B. A significant change in the resident's physical, mental, or psychosocial status [i.e. deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications] ...C. A need to alter treatment significantly [i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment]; A need to alter treatment			

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	significantly means a need to stop a form of treatment because of adverse consequences...or commence a new form of treatment to deal with a problem..." 3.1-49(f)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure multiple use equipment was disinfected after use on residents for 1 of 8 residents reviewed during a medication administration observation. (Resident 9 and LPN 1) Finding includes: During a medication pass observation on 9/19/24 at 11:12 a.m., LPN 1 was observed preparing Resident 9's medications. The nurse indicated she had to check the resident's blood pressure prior to giving him his medications. She removed a blood pressure wrist cuff from her medication cart and took it into the resident's room. She then proceeded to apply the blood pressure cuff to the resident's right wrist and turn on the machine. The blood pressure was completed and the LPN removed the blood pressure cuff and returned the blood pressure cuff to the medication cart. The LPN then proceeded to prepare and administer the residen'ts medication before moving onto the next residents. The LPN was not observed to clean the blood pressure cuff before or after applying it to the resident's wrist. During an interview after the observation, LPN 1 indicated she normally would clean the blood pressure cuff before and after	F 0880	**Tag number: F880 Infection Control** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 9 had no adverse outcomes related to the alleged deficient practice. II. 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 the alleged deficient practice. LPN 1 educated on the proper procedure for disinfecting multi use equipment to include blood pressure cuffs III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nursing staff on the policy "Cleaning & Sanitizing - Wheelchairs and Other Medical Equipment" to include cleaning multi use equipment IV. How the corrective action(s)	11/01/2024

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	using it on a resident and she did not. During an interview on 9/19/24 at 11:44 a.m., the Regional Vice President of Operations indicated the LPN should have cleaned the blood pressure cuff prior to using it on the resident. A policy titled, "Cleaning & Sanitizing - Wheelchairs and Other Medical Equipment", received as current from the facility on 9/19/24, indicated, "...5. Devices/equipment used for more than one resident shall be cleaned between each resident..." 3.1-18(b)		will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee to do random audits to ensure nursing staff are following proper disinfecting procedures. Audits will be completed on 3 nurses a week x 8 weeks, then 1 nurse a week x 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	
F 9999 Bldg. 00	3.1-18 Infection control program (h) All skin testing for tuberculosis shall be done using the Mantoux method administered by persons having documentation of training from a department approved course of instruction in intradermal tuberculin skin testing, reading and recording. 3.1-14 Personnel (t)(1) At the time of employment, or within one (1) month prior to employment, and at least annually	F 9999	**Tag number: F9999** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the alleged deficient practice. II. 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; CNA 1 was given a 1st and 2nd step PPD by date of compliance by a trained	11/01/2024

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	thereafter, employees and nonpaid personnel of facilities she be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure staff had received Mantoux (intradermal tuberculosis test) training by an approved course prior to administering the Mantoux test to 5 of 6 new employee records reviewed. (Employee 7, RN 3, RN 4, RN 5, LPN 3, Administrator and Director of Nursing) The facility also failed to ensure a new employee had been tested for tuberculosis prior to working in the facility for 1 of 6 new employee records reviewed. (CNA 1) Findings include: 1. The records for Employees 2, 3, 4, 5 and 6 were reviewed on 9/19/24 at 12:50 p.m. The following Mantoux test were completed: a. Employee 2: 5/17/24 Administered and read by Employee 7. 6/2/24 Administered and read by Employee 7. b. Employee 3: 5/28/24 Administered and read by RN 3. 6/17/24 Administered and read by RN 4. c. Employee 4: 6/14/24 Administered and read by		staff member. A full house audit was completed on all new hires in the past 30 days to ensure they received their 1st and 2nd step PPD and it was administered by a trained staff member. Nurses to be trained on administering a PPD by date of compliance. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to train nurses on administering a PPD. HR director educated on monitoring administration of 1st and 2nd step PPDs upon hire IV. 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; HR director/designee to complete an audit on all new hires to ensure they were given their 1st and 2nd step PPDs by a trained staff member. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	

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	RN 5. 6/26/24 Administered and read by RN 5. d. Employee 5: 9/10/24 Administered and read by the Director of Nursing. e. Employee 6: 7/23/24 Administered and read by the Administrator. 8/10/24 Administered and read by LPN 3. During an interview on 9/19/24 at 2:30 p.m., the Human Resource (HR) Director indicated none of the above staff who administered or read the Mantoux tests were certified. She was unaware it was a state rule. 2. During an interview on 9/19/24 at 9:52 a.m., CNA 1 indicated she had started working at the facility on 8/20/24. She had not yet received a Mantoux test and had not received one at her previous job for at least a year. CNA 1's Mantoux test was requested from HR for review. It was not available. During an interview on 9/19/24 at 10:30 a.m., the HR Director indicated she did not have CNA 1's Mantoux test. She had meant to follow up with the previous employer, but did not. This citation relates to Complaint IN00442992.			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaint IN00442992.	R 0000		

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	Complaint IN00442992- State deficiencies related to the allegations are cited at F9999. Survey dates: September 16, 17, 18, 19, 20 and 23, 2024. Facility number: 000471 Residential Census: 5 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/30/24.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure Semi-Annual Evaluations were completed at least every six (6) months for 2 of 7 records reviewed. (Residents 1 and 6) Findings include: 1. Resident 1's record was reviewed on 9/20/24 at 1:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and hypertension. The last AL Functional Assessment was completed on 12/13/23. During an interview on 9/23/24 at 9:07 a.m., the Nurse Consultant indicated the AL Functional Assessment was their Semi-Annual Evaluation and there were no additional assessments for the resident. 2. Resident 6's record was reviewed on 9/23/24 at 9:31 a.m. Diagnoses included, but were not limited	R 0214	**Tag number: R214 Evaluation** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 1 had a semi-annual evaluation completed on 9/23/24. Resident 6 no longer resides in assisted living. II. 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 the alleged deficient practice. A full house audit was completed to ensure all residents had a semiannual assessment completed per regulations. III. What measures will be put into place and what systemic changes	10/11/2024

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	155572	A. BUILDING 00 B. WING	09/23/2024

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	to, bipolar disorder, major depressive disorder, and type 2 diabetes mellitus. A Semi-Annual Evaluation was completed on 12/13/23. There were no other Semi-Annual Evaluations available for review. During an interview on 9/23/24 at 10:37 a.m., the Nurse Consultant indicated the Semi-Annual Evaluation was overdue and should have been completed every 6 months.		will be made to ensure that the deficient practice does not recur; SSD educated on the regulation for completing semiannual assessments IV. 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; SSD/designee to audit resident semiannual assessments to ensure they are being completed timely. Audits will be completed 1x week for 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	
R 0215 Bldg. 00	410 IAC 16.2-5-2(b) Evaluation - Deficiency Based on record review and interview, the facility failed to complete a Pre-Admission Evaluation for 1 of 7 residents reviewed. (Resident 5) Finding includes: Record review for Resident 5 was completed on 9/23/24 at 9:28 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, depression, and congestive heart failure. The	R 0215	**Tag number: R215** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 5 had no adverse outcomes related to the deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be	11/01/2024

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	resident was admitted to the facility on 7/30/24. There was a lack of documentation that a Pre-Admission Evaluation had been completed prior to the resident being admitted to the facility. During an interview on 9/23/24 at 10:35 a.m., the Administrator indicated the resident transferred from their Healthcare side to the Assisted Living side. A Pre-Admission Evaluation was missed and not completed.		identified and what corrective action(s) will be taken; Any resident admitted to assisted living has the potential to be affected by the alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Admissions director educated on completed a preadmission evaluation on any resident being evaluated for assisted living IV. 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; Administrator/designee will audit all possible admission to ensure a preadmission assessment has been completed. Audits will be completed weekly x 3 months The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on record review and interview, the facility failed to ensure a medication self-administration	R 0216	**Tag number: R216** I. What corrective action(s) will be	11/01/2024

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	evaluation was completed for 2 of 7 residents reviewed. (Residents 2 and 6) Findings include: 1. Resident 2's record was reviewed on 9/20/24 at 1:31 p.m. Diagnoses included, but were not limited to, bipolar disorder, Alzheimer's disease, and schizophrenia. The resident was admitted to the facility on 5/10/99. The September 2024 Physician Order Summary indicated the resident self-administered diclofenac sodium 1% topical gel (pain relief gel), 2 grams to left foot topically every day and night. The most recent Service Plan, dated 11/1/23, indicated staff was to administer medications to the resident and he did not self-administer any medications. There was a lack of any self-administration of medications assessment related to the diclofenac sodium gel. During an interview on 9/23/24 at 10:58 a.m., the Nurse Consultant indicated the last self-administration of medication assessment was completed in 2022, but staff should have assessed every 6 months. 2. Resident 6's record was reviewed on 9/23/24 at 9:31 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and type 2 diabetes mellitus. The most recent Service Plan, dated 4/26/24, indicated the resident was able to self-administer nasal spray, lotion, and inhaler which he kept at		accomplished for those residents found to have been affected by the deficient practice; Resident 6 no longer resides in assisted living. Resident 2 had a med self-administration assessment completed on 10/15/24. II. 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 the alleged deficient practice. A full house audit was completed to ensure any resident who keeps meds at bedside had a medication self-administration assessment completed. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee will educate nursing staff on completing medication self-administration assessments on any resident who keeps meds at bedside. IV. 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 medication self-administration assessments to ensure they are completed as per regulations. Audits will be completed weekly x 3 months. The results of these audits will be	

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	the bedside. The September 2024 Physician Order Summary indicated the resident was able to self administer the following medications: - Fluticasone propionate suspension (nasal spray) 50 micrograms/actuation 1 spray each nostril once daily - Ipratropium albuterol solution 0.5-2.5 3 milligram per 3 milliliter inhalation once every 12 hours - Biofreeze gel 4% (topical pain reliever), apply to bilateral hips twice daily There were no self-administration of medication assessments completed related to the medications. During an interview on 9/23/24 at 10:58 a.m., the Nurse Consultant indicated the self-administration of medication assessment should have been completed every 6 months.		reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure Service Plans were completed, revised and updated for 2 of 7 residents reviewed. (Residents 5 and 2) Findings include: 1. Record review for Resident 5 was completed on 9/23/24 at 9:28 a.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, depression, and congestive heart failure. The resident was admitted to the facility on 7/30/24. There was no documentation to indicate a Service Plan had been completed after the resident	R 0217	**Tag number: R217** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 5's service plan was completed on 10/25/24, resident 2's service plan was completed on 10/28/24 II. 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 the alleged deficient	11/01/2024

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	admitted to the facility. During an interview on 9/23/24 at 10:35 a.m., the Administrator indicated the resident transferred from their Healthcare side to the Assisted Living side. A Service Plan had not been completed on the resident. 2. Resident 2's record was reviewed on 9/20/24 at 1:31 p.m. Diagnoses included, but were not limited to, bipolar disorder, Alzheimer's disease, and schizophrenia. The resident was admitted to the facility on 5/10/99. The most recent Service Plan, dated 11/1/23, indicated the resident had a mental status diagnosis of schizophrenia and was seen by a Licensed Clinical Social Worker for talk therapy services. There was no documentation in the record reflecting psychiatric services provided, including a Physician's Order for services. During an interview on 9/23/24 at 12:33 p.m., the Nurse Consultant indicated the Service Plan was outdated. The resident had never been seen by psychiatric services and it was believed to be marked in error on the Service Plan.		practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; SSD educated on completing service plans timely for residents. IV. 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; SSD will audit service plans to ensure they are completed timely. Audits will be completed weekly x 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/1/24	