STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155401	A. BUILDING 00 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BEN HUR HEALTH AND REHABILITATION	1375 S GRANT AVE CRAWFORDSVILLE, IN 47933

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 25, 26, 29, 30, 31, and September 1, 2022. Facility number: 000461 Provider number: 155401 AIM number: 100275290 Census Bed Type: SNF/NF: 78 Total: 78 Census Payor Type: Medicare: 2 Medicaid: 58 Other: 18 Total: 78 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 9, 2022.	F 0000	**Ben Hur Annual Survey POC 2022** The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after.	
F 0568 SS=D Bldg. 00	483.10(f)(10)(iii) Accounting and Records of Personal Funds §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any			

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

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	commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. Based on interview and record review, the facility failed to ensure a resident was provided a quarterly statement for their personal funds account for 1 of 1 residents reviewed for personal funds (Resident 60). Findings include: During an interview, on 8/25/22 at 2:17 p.m., Resident 60 indicated she had not received a quarterly statement for her personal funds account. She had asked for one. Resident 60's record was reviewed on 8/31/22 at 2:25 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 7/16/22, indicated the resident was cognitively intact. Census information indicated the resident was admitted to the facility on 5/13/21 and resided on the Cottage (memory care unit). A care plan, initiated 4/18/22, indicated the resident's cognitive level was assessed within normal limits at times, but it was determined a structured, secure memory care environment was beneficial and appropriate. The reason for placement was the resident's dementia allowed for testing well on assessments but presented with safety needs that required a secure setting. A letter, dated 7/13/22, indicated the resident's responsible party was mailed two copies of the account ledger sheet and requested a signed copy	F 0568	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. **F tag: 568 - Accounting and Records of Personal Funds – Failed to ensure a resident was provided a quarterly statement for their personal funds account for 1 of 1 residents reviewed** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: **Resident 60 was provided a quarterly statement** - 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	09/23/2022

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	be returned. The letter lacked documentation the signed copy was returned to the facility. The electronic record lacked documentation the resident was provided a quarterly statement for her personal funds account. During an interview, on 9/1/22 at 10:40 a.m., the Executive Director (ED) indicated if a resident resided on the Cottage, they were not provided with their personal funds account quarterly statement. It was mailed to their resident representative instead. If a resident requested a statement, they would have provided it. During an interview, on 9/1/22 at 11:51 a.m., Resident 60 indicated she wanted to receive her personal funds account statement quarterly. If the statement was sent to her family, it was most likely sent to her son. Her son would not have paid much attention to what the facility sent him or communicated those things with her very much. She had not been offered a statement. On 9/1/22 at 1:14 p.m., the ED provided a document titled, "QUARTERLY STATEMENTS," and indicated it was the policy currently being used by the facility. The policy indicated, "...POLICY: Federal regulations require that each quarter the Resident or his/her Responsible Party be provided with quarterly accounting of the Resident Trust Account...PROCEDURE: ...For residents in the facility who can handle their own finances, give two copies of the quarterly statement to the Social Services Director. The Social Services Director will get both statements signed by the resident leaving one copy with the resident and returning the other signed copy to the Business Office...For residents who are unable to manage their own finances, send two copies of		**All residents with a personal funds account has the potential to be affected** **All residents, or their responsible party, with personal fund accounts will be interviewed regarding their preference to receive a quarterly statement** - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Residents who currently have a personal funds account and those who open a funds account in the future, will be interviewed regarding their preference to receive a quarterly statement; a quarterly statement will be provided to the residents who prefer to receive one** **The Business Office Manager and Social Service Director will receive training on resident personal funds account** - how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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	the quarterly statement along with a letter on letterhead to the responsible party...." 3.1-6(g)		program will be put into place; To ensure compliance, the ED/Designee is responsible for the completion of the **Personal Funds Account** CQI tool weekly times 4 weeks, monthly times 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. - by what date the systemic changes will be completed. **9/23/2022**	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or			

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	possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on record review and interview, the facility failed to ensure residents were re-evaluated for the need of a Preadmission Screening and Resident Review (PASRR) (a screening to ensure nursing home placement is appropriate) Level II (an assessment that ensures residents with mental illness and intellectual disabilities receive the services they need) assessments with changes in diagnosis for 1 of 1 residents reviewed for PASRR (Resident 38). Findings include: Resident 38's record was reviewed on 8/26/22 at 2:06 p.m. A significant change Minimum Data Set (MDS) assessment, dated 9/10/21, indicated the resident was not considered by the state Preadmission Screening and Resident Review (PASRR) (a screening to ensure nursing home placement is appropriate) process to have a serious mental illness and had a severe cognitive impairment. Census information indicated the resident was admitted to the facility on 3/29/19. A Level I PASRR, dated 3/26/19, indicated no Level II (an assessment that ensures residents with mental illness and intellectual disabilities receive the services they need) assessment was required related to no serious mental illness diagnosed. A diagnosis, dated 8/16/21, indicated psychotic disorder (a mental disorder characterized by a disconnection from reality) with delusions (fixed,	F 0644	**F tag: 644 – Coordination of PASARR and Assessments – Failed to ensure residents were re-evaluated for the need of PASARR Level II assessments with changes in diagnosis for 1 of 1 residents reviewed** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **An update PASARR has been submitted for resident 38 with new diagnosis, no level II required** - 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 with a serious mental disorder, intellectual disability, or a related condition for Level II has the potential to be affected** **All Residents will be reviewed for addition of new diagnoses that could impact the need for a Level II** - what measures will be put	09/23/2022

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	false beliefs) due to known physiological condition. The electronic record lacked documentation the resident was referred for a Level II PASRR after the addition of the diagnosis. During an interview, on 8/31/22 at 11:24 a.m., the Executive Director (ED) indicated she reviewed the resident's PASRR, and it was not re-submitted for a Level II when the psychotic disorder diagnosis was added. It should have been reviewed with the addition of the diagnosis. On 8/31/22 at 11:24 a.m., the ED provided a document titled, "PAS Paperwork," and indicated it was the policy currently being used by the facility. The policy indicated, "...Pre-Admission Screening (PAS) is a requirement for Nursing Facilities in the State of Indiana...PAS paperwork is used to...2. Assure persons with major mental illness continue recommended treatment in the nursing facility...Maintaining PreAdmission Forms after Admission: Level I Screen. The nursing facility is responsible for submitting a Level I screen for any resident who: ...Requires an updated Level I screen because of a change in medication, diagnoses, etc...." 3.1-16(d)(1)		into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Education will be provided to the Memory Care Support Specialist, Social Services Director and MDS Coordinator regarding diagnosis changes that require a new PASARR** **The Memory Care Support Specialist, Social Services Director and MDSC will review new orders for the addition of diagnoses during clinical meeting that need a new PASARR for possible Level II** - 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 To ensure compliance, the ED/Designee is responsible for the completion of the **PASSAR Screening for Level II's** CQI tool weekly times 4 weeks, monthly times 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	

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			ensure compliance. - by what date the systemic changes will be completed. **9/23/2022**	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility	F 0657	**F tag: 657– Care Plan Timing**	09/23/2022

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	failed to ensure a resident was invited to their care plan meeting (Resident 60) and care plans were developed (Residents 2, 52, and 14) for 4 of 21 residents reviewed for care planning. Findings include: 1. During an interview, on 8/25/22 at 2:19 p.m., Resident 60 indicated she had not been invited to or attended a care plan meeting. Resident 60's record was reviewed on 8/31/22 at 2:25 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 7/16/22, indicated the resident was cognitively intact. Census information indicated the resident was admitted to the facility on 5/13/21. A care plan summary observation, dated 8/18/21, indicated a care plan meeting was held with the Dementia Care Director and Social Services Director (SSD) in attendance. The resident's representative had not responded to the care plan meeting invitation. The summary lacked documentation the resident was invited or declined attending the meeting. A progress note, dated 11/11/21, indicated a care plan was scheduled for the following day by phone. The note lacked documentation of who the care plan was scheduled with. The electronic record lacked documentation the care plan meeting was held the following day. A care plan summary observation, dated 4/20/22, indicated a care plan meeting was held with the Dementia Care Director and SSD in attendance. The summary lacked documentation the resident or resident's representative were invited or		**and Revision – Failed to ensure a resident was invited to their care plan meeting and care plans were developed for 4 of 21 residents reviewed** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **Resident 60 was offered a care plan meeting** **Care plans were developed for residents 2, 52 and14** - 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** **All residents to be reviewed for evidence of a care plan meeting invitation within the past quarter. A care plan meeting will be scheduled for any residents without evidence of a care plan meeting invitation** **All residents care plans to be reviewed for accurate reflection of pertinent resident diagnoses and resident conditions/behaviors**	

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	declined attending the meeting. An undated care plan invitation post card indicated the resident's representative was mailed an invitation to a care plan on 4/27/22. The electronic record lacked documentation of a response to this invitation, or a care plan meeting was held on this date. An undated care plan invitation post card indicated the resident's representative was mailed an invitation to a care plan on 7/7/22. The electronic record lacked documentation of a response to this invitation, or a care plan meeting was held on this date. During an interview, on 9/1/22 at 9:36 a.m., the Executive Director (ED) indicated if residents were alert enough to attend a care plan meeting and had an interest in attending, they would have been invited. She was unsure if Resident 60 attended her care plan meetings. The invitations and responses should have been documented in the progress notes. Care plan meetings were documented with the care plan summary observations. During an interview, on 9/1/22 at 10:15 a.m., the ED indicated she was unable to find any additional documentation regarding Resident 60's care plan meetings. 2. Resident 2's record was reviewed on 8/29/22 at 2:35 p.m. An admission Minimum Data Set (MDS) assessment, dated 5/4/22, indicated the resident had a severe cognitive impairment and had not demonstrated behaviors during the assessment period. Census information indicated the resident was		- what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Education will be provided to SSD and MCSS regarding care plan meeting invitations** **Education will be provided to the Interdisciplinary Team regarding developing care plans for pertinent diagnoses and resident conditions/behaviors** **The IDT Care Plan Pathway and Review Guidelines will be used during the IDT care plan reviews** - 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; To ensure compliance, the DNS/Designee is responsible for the completion of the **Comprehensive Care Plan Review QAPI tool** weekly times 4 weeks, monthly times 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	

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	admitted to the facility on 4/27/22. Diagnoses on the resident's profile included, but were not limited to, unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) with behavioral disturbance, generalized anxiety disorder (persistent worrying or anxiety about a number of areas that are out of proportion to the impact of the events), and post-traumatic stress disorder unspecified (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). A progress note, dated 5/1/22, indicated the resident repeatedly hit the wall and table and screamed for help. When staff attempted to provide assistance, the resident stated he either wanted to go back to bed or back in his wheelchair. A progress note, dated 5/3/22, indicated the resident was confused, and banged on the wall while yelling for help. A progress note, dated 5/24/22, indicated while a certified nursing assistant (CNA) provided care to the resident and the resident used his urinal, the resident told the CNA he wanted to kiss her breast. The resident was reminded this was inappropriate, and the resident responded he just had to say it. An interdisciplinary team (IDT) note, dated 5/24/22, indicated the resident's behavior was reviewed with a root cause of impaired vision and low cognitive level caused resident to mistake caregivers for his wife at times. Staff was to introduce themselves by name and title before		threshold of 95% is not achieved an action plan will be developed to ensure compliance. - what date the systemic changes will be completed. **9/23/2022**	

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	providing care. A new or worsening behavior event, dated 5/24/22, indicated the resident made inappropriate comments to staff. A progress note, dated 6/12/22, indicated the resident was in the dining room at dinner time and stated he was in jail. The resident was going around to other residents telling them the facility did nothing but trapped them there. Resident continuously stated he had to go to the bathroom, and repeatedly attempted to open the cabinets and oven. Progress notes, dated 6/14/22, indicated the resident was in the dining room talking with other residents, became loud, asking other residents why he was here, and stated he did not do anything. The resident asked other residents to push him around in his wheelchair and take him to the curb so he could drive or call a cab to go home. During this time, the resident took another resident's hand, made contact with her, and told her she was a good person. A new or worsening behavior event, dated 6/14/22, indicated the resident told other residents he was being kept in jail. A progress note, dated 6/24/22, indicated the CNA assisted the resident to bed from the restroom. Upon his return to bed, the resident slapped the CNA multiple times. A new or worsening behavior event, dated 6/24/22, indicated the resident had a physical altercation with staff. A progress note, dated 6/25/22, indicated the			

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	resident was combative with staff during care, dumped supper tray onto the floor, and blamed staff for the tray falling. A progress note, dated 6/26/22, indicated the resident was combative at times with care and was difficult to redirect. A progress note, dated 6/29/22, indicated the resident yelled out wanting to know why he was being held here, staff was stupid, and wanted to call the police. A new or worsening behavior event, dated 6/29/22, indicated the resident yelled at staff and called them stupid. He requested to go to the bathroom without remembering he had just gone and argued with his roommate that he was able to get up on his own. A physician communication event, dated 6/29/22, indicated the resident was more argumentative with staff, thought he was in jail, and called staff stupid. A progress note, dated 6/30/22, indicated the resident became agitated and verbally aggressive towards staff when offered the urinal. A new order event, dated 7/1/22, indicated a psychiatric evaluation was to be completed. A progress note, dated 7/3/22, indicated the resident presented with extreme agitation and anxiety, yelled at staff and other residents, and attempted to coerce other residents to assist with his needs as well as those of other residents. A new order event, dated 7/12/22, indicated trazodone (an antidepressant) 25 milligrams (mg)			

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	by mouth daily at bedtime. A hot charting event, dated 7/20/22, indicated the resident was monitored for psychosocial distress due to resident to resident contact. A new or worsening behavior event, dated 7/30/22, indicated the resident had a new behavior. A progress note, dated 8/2/22, indicated the resident exposed his penis, and yelled out that he wanted to go home and asked why the staff was keeping him here. When campus peers approached him, he attempted to kiss their hands, puckered his lips, and blew kisses in the air at campus peers. A new or worsening behavior event, dated 8/2/22, indicated the resident attempted to kiss other residents' hands and yelled out about why he was being kept in the facility. A progress note, dated 8/3/22, indicated the resident was in the dining room, attempted to pull down pants in front of other residents. The resident was assisted to the bathroom but did not void. He was returned to the dining room and attempted to take off all of his clothes twice. Resident yelled out he could not be kept there. The physician was notified, and Depakote was ordered for inappropriate sexual behaviors. A new order event, dated 8/3/22, indicated resident was to be sent to an inpatient psychiatric unit for evaluation and treatment. A new order event, dated 8/3/22, indicated Depakote sprinkles (a mood stabilizer) 250 mg by mouth twice daily for inappropriate sexual			

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	155401	A. BUILDING 00 B. WING	09/01/2022

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	behaviors. A care plan, dated 8/4/22, indicated the resident had a behavioral expression of indecent exposure in the common area. A progress note, dated 8/5/22, indicated the resident's wife was updated regarding inpatient psychiatric referrals. The resident's wife wanted to consider hospice (specialized care for the terminally ill) services for the resident. She talked to the physician who said if the resident was denied to inpatient psychiatric facilities, a hospice referral would be made. A new order event, dated 8/8/22, indicated hospice to evaluate and treat. A care, initiated 8/9/22, indicated the resident had a history of refusing and combativeness with care, and had a contributing diagnosis of dementia. The electronic record lacked documentation a care plan was developed for care refusal prior to 8/9/22. A care plan, initiated 8/9/22, indicated per the resident's wife, the resident had a history of being a prisoner of war, and at times believed he was held captive or in jail. The resident had a contributing diagnosis of dementia. The electronic record lacked documentation a care plan was developed for the history prior to 8/9/22. A new order event, dated 8/10/22, indicated the resident was admitted to hospice services, and included, but was not limited to orders for trazodone increased to 50 mg by mouth daily at bedtime, and lorazepam (an antianxiety) 0.5 mg by mouth every 4 hours as needed (PRN) for 14 days, continue psychiatric services as ordered.			

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	A care plan, initiated 8/15/22, indicated the resident was at risk for anxiety. The care plan lacked documentation of any specific behaviors the resident exhibited. A new order event, dated 8/17/22, indicated give lorazepam 0.5 mg, 1 tablet, by mouth at bedtime for anxiety. A new order event, dated 8/23/22, indicated start Lexapro (an antidepressant) 5 mg by mouth daily for 7 days, then increased to 10 mg by mouth daily. A care plan, initiated 8/26/22, indicated the resident was at risk for adverse side effects related to use of psychotropic medication, antidepressant and antianxiety. The electronic records lacked documentation a care plan was developed for psychotropic medication usage prior to 8/26/22. Two printed care plans were provided by the Executive Director (ED) on 8/31/22 at 10:49 a.m. The care plans indicated the resident had expressed delusions of alcohol be consumed by visitors and believed campus peers were responsible for his chair rolling into objects with a problem start date of 6/26/22, and the resident was at risk for verbal sexual remarks towards staff during care with a problem start date of 5/25/22. Both care plans indicated they were last reviewed and revised on 8/31/22. At the same time, the ED reviewed the resident's care plans from the record review and indicated those care plans were not included. There should have been behavior care plans put in place when new and worsening behaviors were noted. During an interview, on 8/31/22 at 11:00 a.m., the ED indicated upon further review, the care plans			

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	for behavior monitoring provided on paper were initiated yesterday and should have been initiated on the dates indicated in the care plans. Care plans should have been developed for behaviors. 3. Resident 52's record was reviewed on 8/26/22 at 2:14 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 7/1/22, indicated the resident was cognitively intact and reported occasional mild pain. Diagnoses on the resident's profile included, but were not limited to, migraine with aura (recurring headache that strikes after or at the same time as sensory disturbances), intractable (not improving), without status migrainosus (lasting longer than 72 hours). A physician's order, dated 4/14/22, indicated Excedrin Migraine (aspirin-acetaminophen-caffeine) 250-250-65 milligrams (mg) by mouth every 6 hours as needed (PRN) for migraine with aura, intractable, without status migrainosus. A medication administration record (MAR), dated August 2022, indicated the resident received Excedrin-Migraine 250-250-65 mg by mouth 4 times during the month. Current care plans lacked a care plan for migraines. During an interview, on 8/29/22 at 1:25 p.m., the Director of Nursing (DNS) indicated there should have been a care plan in place for migraines. 4. Resident 14's record was reviewed on 8/26/22 at 2:17 p.m. An active diagnosis on the resident's profile included, but was not limited to,			

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	unspecified dementia without behavioral disturbance (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), dated 12/17/19. A quarterly Minimum Data Set (MDS) assessment, dated 5/20/22, indicated the resident was cognitively intact, did not have any behavioral disturbances during the assessment period, and had a diagnosis of dementia. Review of Resident 14's care plans lacked documentation a dementia care plan had been created for the resident. During an interview, on 8/29/22 at 10:57 a.m., the Social Services Director (SSD) indicated Resident 14 should have a dementia care plan, since the resident had a dementia diagnosis. On 08/29/22 at 11:35 a.m., the Executive Director indicated, Resident 14 had a diagnosis of dementia and should have had a dementia care plan developed. At the same time, the ED provided and identified a document as a current facility policy titled, "IDT Comprehensive Care Plan Policy," dated 10/2019. The policy indicated, "...Policy: It is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental, and psychosocial needs...Procedure: ...Resident, resident's representative, or others as designated by resident will be invited to care plan review...The care plan review may be conducted face to face, via phone conference, video			

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	conference, or through written communication per resident and/or representative preference...Care plan problems, goals, and interventions will be updated based on changes in resident assessment/condition, resident preferences or family input...." 3.1-35(b)(1) 3.1-35(d)(2)(B)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the			

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	identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on record review and interview, the facility failed to address pharmacy recommendations in a timely manner for 2 of 5 residents reviewed for unnecessary medications (Resident 64 and 14). Findings include: 1. Resident 64's record was reviewed on 8/29/22 at 11:47 a.m. The profile indicated the resident's diagnoses included, but were not limited to chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breathe), constipation, and chronic pain. An annual Minimum Data Set (MDS) assessment, dated 1/3/22, indicated the resident had no cognitive deficit and reported occasional mild pain. A quarterly MDS assessment, dated 6/23/22, indicated the resident had cognitive deficit, reported frequent mild pain and received an opiod (substances that act on opiod receptors to	F 0756	**F tag: 756 – Drug Regimen Review – Failed to address pharmacy recommendations in a timely manner for 2 of 5 residents reviewed** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **The pharmacy recommendations for residents 64 and 14 had already been accurately addressed in January 2022. All subsequent pharmacy recommendations have been addressed within 30 days. Residents 64 and 14 had no negative outcomes and continue to reside in the facility** - how other residents having the potential to be affected by the	09/23/2022

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	produce morphine-like effects) pain medications. A care plan, dated 4/23/21, indicated the resident was at risk for pain related to diagnoses which included, but were not limited to COPD, and constipation. Interventions included, but were not limited to, administer medications as ordered. A pharmacy recommendation, dated 9/16/21, indicated to consider discontinuing (DC) the following as needed (PRN) medications which had not been used for 60 days: Tylenol (acetaminophen) suppository (rectally inserted medication used to treat mild to moderate pain and fever), bisacodyl suppository (rectally inserted medication used to relieve constipation), and duonebs (aerosol medication used to treat and prevent symptoms (wheezing and shortness of breath) caused by ongoing lung disease). A pharmacy recommendation, dated 11/15/21, indicated to consider discontinuing the following PRN medications which had not been used for 60 days: Tylenol (acetaminophen) suppository, bisacodyl suppository, and duonebs. Review of a discontinued medication order, indicated acetaminophen suppository 650 milligrams (mg) give rectally for fever, every 4 hours, PRN, had not been discontinued until 1/13/22. Review of a discontinued medication order, indicated bisacodyl suppository 10 mg give 1 suppository rectally, one time daily, PRN for constipation, had not been discontinued until 1/13/22. Review of a discontinued medication order, indicated ipratropium (a medication that opens the		same deficient practice will be identified and what corrective action(s) will be taken **All residents have the potential to be affected** **All residents' pharmacy recommendations will be reviewed for timely follow up** - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Regional Director of Clinical Services reviewed effectiveness of current process/action plan for addressing pharmacy recommendations with DNS** **DNS will continue to review weekly for timely follow up to recommendations received in prior week** - 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; To ensure compliance, the **DNS/Designee is responsible for the completion of the Pharmacy Recommendations QAPI tool weekly** times 4 weeks, monthly times 6 and then	

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	airways)-albuterol (a medication that decreases inflammation in the lungs) solution (duonebs), for nebulization (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) 0.5 mg-3 mg, give one vial every 6 hours PRN for wheezing/shortness of breath (SOB) had not been discontinued until 1/5/22. During an interview, on 8/29/22 at 2:20 p.m., the Executive Director (ED) indicated the previous Director of Nursing (DON) had left the position in the fall of 2021. The Assistant Director of Nursing (ADON) was promoted into the DON position shortly after. The concerns with the timeliness of the pharmacy recommendations was not discovered until December. 2. Resident 14's record was reviewed on 8/26/22 at 2:17 p.m. Diagnoses included, but were not limited to heart failure, nonvalvular atrial fibrillation (irregular heartbeat rhythm) (AFib), end stage renal disease (kidney failure), and unspecified dementia without behavioral disturbance (mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems). A quarterly Minimum Data Set (MDS) assessment, dated 5/20/22, indicated the resident was cognitively intact, received an anticoagulant (blood thinner) medication, and received dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys stopped working properly). A care plan, initiated on 10/23/19, indicated the resident was at risk for abnormal/excessive bleeding due to use of an anticoagulant medication. Interventions on the care plan included, but were not limited to, administer medication as ordered and to observe for adverse		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. - what date the systemic changes will be completed. **9/23/2022**	

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	effects of medication, such as blurred vision, nausea, decreased appetite, headache, joint pain, and shortness of breath. A pharmacy recommendation, dated 9/16/21, indicated Resident 14 received Eliquis (apixaban) (medication used to prevent serious blood clots from forming due to an irregular heartbeat) 2.5 milligrams (mg) twice daily for the prevention of systemic emboli (blood clot) due to AFib and to please to increase the dose of Eliquis to 5 mg twice daily. The drug manufacturer recommended dose when used in AFib in a dialysis patient is 5 mg twice daily. The Director of Nursing Services (DNS) signed and documented on the recommendation the doctor's office was called on 12/30/21 at 2:45 p.m. and a new order was received on 1/7/22 to increase the Eliquis to 5 mg twice daily. A pharmacy recommendation, dated 11/15/21, indicated Resident 14 received Eliquis (apixaban) (medication used to prevent serious blood clots from forming due to an irregular heartbeat) 2.5 milligrams (mg) twice daily for the prevention of systemic emboli (blood clot) due to AFib and to please to increase the dose of Eliquis to 5 mg twice daily. The drug manufacturer recommended dose when used in AFib in a dialysis patient is 5 mg twice daily. The physician and the DNS agreed with the recommendation and signed the recommendation on 1/3/22. A current August 2022 physician's orders indicated Resident 14 received Eliquis 5 milligram (mg) tablet twice a day for the diagnosis of paroxysmal AFib (episodes of AFib that occurred occasionally and usually stopped spontaneously) with a start date of 4/16/22.			

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	During an interview, on 8/29/22 at 9:33 a.m., the Executive Director (ED) indicated the previous DNS had left the facility in the fall of 2021 and the Assistant Director of Nursing (ADNS) had taken over the DNS position and started reviewing the pharmacy recommendations in December 2021. The facility and doctor should have addressed and signed the pharmacy recommendations within 30 days of receiving the recommendations. On 8/29/22 at 9:35 a.m., the ED provided and identified a document as a current facility policy, titled "Medication Regimen Reviews and Pharmacy Recommendations," dated 10/2018, which indicated, "...Purpose: It is the policy of ASC that the facility maintains the resident's highest practicable level of physical, mental, and psychosocial well-being and prevents or minimizes adverse consequences related to medication therapy to the extent possible by providing oversight by a licensed Pharmacist, Attending Physician, Medical Director, and Director of Nursing...The Consultant Pharmacist recommendations will be reviewed by the Director of Nursing and the Attending Physician will be notified promptly of any recommendations needing immediate attention...Pharmacy recommendations should be reviewed with follow up by the physician within 30 days of the facility receiving...Once reviewed by the Physician the pharmacy recommendations will be filed in the resident's medical record...." 3.1-25(j)			
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			

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	from unnecessary drugs. An unnecessary drug is any drug when used- §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 record review and interview, the facility failed to ensure pain assessments were completed for residents who were administered pain medication for 2 of 5 residents reviewed for unnecessary medication (Residents 64 and 52). Findings include: 1. Resident 64's record was reviewed on 8/29/22 at 11:47 a.m. The record indicated the resident had been admitted to the facility on 4/22/21. The profile indicated the resident's diagnoses included, but were not limited to chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breathe) and chronic pain.	F 0757	**F tag: 757 – Unnecessary Drugs – Failed to ensure pain assessments were completed for residents who were administered pain medication for 2 of 5 residents reviewed** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **Residents 64 and 52 had pain assessments documented and pain medications administered per physician orders** - how other residents having	09/23/2022

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	An annual Minimum Data Set (MDS) assessment, dated 1/3/22, indicated the resident had no cognitive deficit and reported occasional mild pain. A quarterly MDS assessment, dated 6/23/22, indicated the resident had cognitive deficit, reported frequent mild pain, and received an opiod (substances that act on opiod receptors to produce morphine-like effects) pain medications. A care plan, dated 4/23/21, indicated the resident was at risk for pain related to diagnoses which included, but were not limited to COPD and constipation. Interventions included, but were not limited to, administer medications as ordered. A physician's order, dated 6/5/22, indicated Tramadol (medication used to relieve moderate to moderately severe pain) Schedule IV tablet (drugs with a low potential for abuse and low risk of dependence), 50 milligrams (mg) by mouth, every 6 hours as needed (PRN) for moderate pain. Review of the July 2022 medication administration record (MAR) indicated the medication had been administered 1 time. The record lacked documentation of assessment of the location and the severity of the pain. Review of the August 2022 MAR indicated the medication had been administered 2 times. Both administrations lacked documentation of assessment of the location and the severity of the pain. 2. Resident 52's record was reviewed on 8/26/22 at 2:14 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 7/1/22, indicated the resident was cognitively intact and reported occasional mild pain.		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** **Licensed staff will receive education on completing and documenting a pain assessment to include location and level of pain and effectiveness of medication** - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Licensed staff will receive education on completing and documenting a pain assessment to include location and level of pain and effectiveness of medication** **Designated nurse manager will do a random review of documentation of PRN doses of pain medications daily for assessment of location and level of pain and effectiveness** - 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;	

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	155401	A. BUILDING 00 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BEN HUR HEALTH AND REHABILITATION	1375 S GRANT AVE CRAWFORDSVILLE, IN 47933

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	Diagnoses on the resident's profile included, but were not limited to, migraine with aura (recurring headache that strikes after or at the same time as sensory disturbances), intractable (not improving), without status migrainosus (lasting longer than 72 hours). A physician's order, dated 4/14/22, indicated Excedrin Migraine (aspirin-acetaminophen-caffeine) 250-250-65 milligrams (mg) by mouth every 6 hours as needed (PRN) for migraine with aura, intractable, without status migrainosus. A medication administration record (MAR), dated July 2022, indicated the resident received Excedrin-Migraine 250-250-65 mg by mouth 1 time during the month. The administration lacked documentation of the resident's pain. A MAR, dated August 2022, indicated the resident received Excedrin-Migraine 250-250-65 mg by mouth 4 times during the month. The administrations lacked documentation of a severity of the resident's pain. During an interview, on 8/29/22 at 1:25 p.m., the Director of Nursing Services (DNS) indicated when a PRN pain medication was administered they should have documented non-pharmacological interventions attempted, pain scale for severity, location of pain, and the effectiveness of the administration about an hour after administration. During an interview, on 8/29/22 at 1:40 p.m., the DNS indicated the pain severity should have been documented in the progress notes because the MAR did not prompt them to document this.		To ensure compliance, the DNS/Designee is responsible for the completion of the **Pain Management QAPI tool weekly** times 4 weeks, monthly times 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. - what date the systemic changes will be completed. **9/23/2022**	

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	On 8/29/22 at 1:39 p.m., the DNS provided a document titled, "Pain Management," and indicated it was the policy currently being used by the facility. The policy indicated, "...POLICY: It is the policy...to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, including pain management. Procedure: 1. Residents are assessed for pain...during medication administration as outlined below. 2. The following will be used when assessing pain...IDT Pain Interview or PAINAD (Pain Assessment in Advanced Dementia Scale). Ongoing nursing assessments can also be documented in matrix progress notes or matrix vitals. 3. Interviewable Resident-Pain medications will be prescribed and given based upon the intensity of the pain as follows using the verbal descriptive, numerical scale (1-10) or Wong-Baker FACES Scale...4. Non-Interviewable Resident-Pain medications will be prescribed and given based upon nursing assessment of the following: NON-VERBAL SOUNDS...VOCAL COMPLAINTS OF PAIN...FACIAL EXPRESSIONS...PROTECTIVE BODY MOVEMENTS OR POSTURES...Wong-Baker FACES Scale...." 3.1-48(a)(3)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;			

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	§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on interview, record review, and observation, the facility failed to ensure the temperature and palatability of food served for 7 of 7 residents reviewed for concerns with food temperatures, and for 1 of 1 test tray reviewed for temperature and palatability. Findings include: During an interview, on 8/26/22 at 10:42 a.m.., Resident 26 indicated the food was nothing to write home about. "I eat breakfast in my room and the food is cold, especially the scrambled eggs and oatmeal." During an interview, on 8/25/22 at 11:49 a.m., Resident 14 indicated he ate meals in his room and the food was cold. During an interview, on 8/26/22 at 10:26 a.m., Resident 69 indicated that sometimes food was not hot enough. The resident ate in the dining room. During an interview, on 08/25/22 11:30 a.m., Resident 4 indicated that hot food was cold during all three meals. During an interview, on 8/25/22 at 2:37 p.m., Resident 52 indicated that food was not always hot. During an interview, on 8/26/22 at10:12 a.m., Resident 58 indicated he ate in his room. Food often was cold, especially the meat.	F 0804	**F tag: 804 – Palatable Food Temps – Failed to ensure temperature and palatability of food served for 7 of 7 residents and for 1 of 1 test trays** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **Residents 26, 14, 69, 4, 52, 58 and 73 receive meals per their preference with offers to replace the meal or warm up if meal is not to resident's satisfaction** - 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 who receive a meal tray have the potential to be affected** **Staff will offer to replace the meal or warm up meal if the resident is not satisfied with meal** - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not	09/23/2022

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F 9999	During an interview, on 8/25/22 at 2:48 p.m., Resident 73 indicated she ate meals in her room and the food was cold. During lunch on 8/30/22 at 11:37 a.m., Dietary Manager obtained the following food temperatures: Tuna Noodle Casserole - 153 degrees Fahrenheit (F) Pureed Tuna Noodle Casserole - 160 F Vegetable Salad - 36 F Green Beans - 170 F Fruit - 36 F Pureed fruit - 30 F Milk - 36 F On 8/30/22 at 12:41 p.m. the test tray food temperatures were: Tuna Noodle Casserole - 111 F Vegetable Salad - 52 F During an interview on 8/30/22 at 12:45 p.m., the Dietary manager indicated that the Tuna Noodle Casserole should be 150 F and vegetable salad should be below 41 F. On 8/30/22 at 12:41 p.m., the Executive Director (ED) provided and identified a document as a current facility policy titled, "Food Temperatures," dated 06/21. The policy indicated that " ...Hot foods will leave the kitchen at or above 135 and cold foods at or below 41...." 3.1-21(a)(2)		recur; **Inservice to staff to offer a meal replacement or to warm up a meal if resident is not satisfied with meal** **ED/Designee will randomly temp food on serving line and during meal service** - 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; To ensure compliance, the ED/Designee is responsible for the completion of the **Food and Nutrition Test Tray CQI tool** weekly times 4 weeks, monthly times 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. - what date the systemic changes will be completed. **9/23/2022**	

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Bldg. 00	3.1-13 ADMINISTRATION AND MANAGEMENT (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (A) Epidemic outbreaks (B) Poisonings (C) Fires; or (D) Major accidents. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident's fall with injury was reported to the State agency in a timely manner for 1 of 1 resident reviewed for falls with injury (Resident 63). Findings include: During an interview, on 8/26/22 at 9:55 a.m., Resident 63 indicated he had a fall about 4 weeks ago and received staples in the back of his head. Resident 63's record was reviewed on 8/30/22 at 11:30 a.m. The profile indicated the resident's diagnoses included, but were not limited to,	F 9999	**F99999 – Administration and Management – Failed to ensure a resident's fall with injury was reported to the state agency in a timely manner for 1 of 1 resident reviewed** - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice **Resident 63 continues to reside in facility and receives assistance with ADL's, nursing care and medications/treatments per physician orders with no negative outcomes** - 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** **Education provided by regional support staff to administrative staff regarding timely reporting of events to the state agency** what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;	09/23/2022

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	generalized muscle weakness (decreased strength in the muscles) and difficulty in walking. Review of fall risk assessment, dated 1/14/22 to 6/14/22, indicated the resident was moderate to high risk for falls. An admission Minimum Data Set (MDS) assessment, dated 1/20/22, indicated the resident had moderate cognitive deficit, required extensive assist of 1 to 2 persons with activities of daily living (ADL's) and locomotion on unit, and had no documented falls or history of falls. A quarterly MDS assessment, dated 6/14/22, indicated the resident had no cognitive deficit, required extensive assist of 1 with ADLs, supervision of 1 person with walk in in room or corridor, and had no documented falls or history of falls. A care plan, dated 1/14/22, indicated the resident was at risk for falls. Interventions included, but were not limited to, therapy referral for transfers and ambulation, assist of 1 with transfers, and non-skid footwear. A fall event document, dated 7/25/22 at 5:00 p.m., indicated the resident had a witnessed fall. The resident was walking to dining room with his walker and assistance from nursing staff. The staff assisting the resident indicated she noticed him becoming weak and informed him his wheelchair was behind him if he felt the need to sit. The resident indicated he was fine and continued walking when he fell. Upon assessment a laceration to back of head and his chin was noted along with a skin tear to his left wrist. A dressing was applied to his head, chin, and left wrist.		**Education provided by regional support staff to administrative staff regarding timely reporting of events to the state agency** **ED/DNS will review the facility activity report daily for documentation** - 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; To ensure compliance, the ED/Designee is responsible for the completion of the **Reportable File QAPI** tool weekly times 4 weeks, monthly times 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. - what date the systemic changes will be completed. **9/23/2022**	

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	A progress note, dated 7/25/22 at 5:25 p.m., indicated the resident was walking to dining room with his walker and assistance from nursing staff. The staff assisting the resident indicated she noticed him becoming weak and informed him his wheelchair was behind him if he felt the need to sit. The resident indicated he was fine and continued walking when he fell hitting his chin on the coffee cart and head on the floor of the dining room. the resident obtained a laceration to back of head, under chin and a skin tear to the left wrist during the fall. Emergency transfer was called. The resident was alert and oriented to person, place, time, and environment, and remained conscious until the emergency medical technicians (EMTs) arrived. He was able to move all extremities freely and reported pain to his head. Vital signs were obtained and were within normal limits for the resident. The resident's daughter, the physician and the Director of Nursing (DON) were contacted. On 8/30/22 at 9:20 a.m., the Executive Director (ED) provided the facility investigation report of the fall event. The investigative report lacked documentation that a IDOH State Reportable event document had been completed. On 8/31/22 at 11:04 a.m., the ED provided a IDOH State Reportable event document, for event dated 7/25/22. At the same time, she indicated the report had not been made to the State regarding the fall event until 8/30/22, when a copy of the reportable event was requested. She did not believe that the facility had a policy addressing reporting events to the state but followed the State regulation that reportable events must be reported to the State within 24 hours of being aware of the event.			