STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	07/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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 the Investigation of Complaint IN00358517. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00358517 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F684, F686, F689, F725, F839, and F842. Survey dates: July 25, 26, & 27, 2021 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Census Bed Type: SNF/NF: 83 Total: 83 Census Payor Type: Medicare: 2 Medicaid: 66 Other: 15 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/30/21.	F 0000	Preparation execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts or alleged or conclusions set forth on the State of Deficiencies. The plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The plan of correction is submitted in order to respond to the allegation of non-compliance cited during survey on July 25th-27th 2021. Please accept this plan of correction as the provider's credible allegation of compliance. The facility would like to request a desk review for this survey.	
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral			

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

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	hygiene; Based on observation, record review, and interview, the facility failed to provide activities of daily living (ADL's) in a timely manner for residents who required extensive to dependent care, related to incontinence care, for which one resident (Resident O) complained of soreness from the urine on her skin, had redness of the skin, and complaints of discomfort due to the soreness when incontinence care was completed, and 4 residents were saturated through the incontinent brief and bottom sheets on the bed (Residents O,M, E, and K). The facility also left a resident (Resident P) in the same position in a recliner chair for a long period of time without position changes or incontinent care, and left residents in soiled gowns, for 6 of 9 residents reviewed for ADL's. (Residents O, M, E, K, J, and P) Findings include: 1) Resident O was observed on 7/25/21: At 10:34 a.m., the resident indicated she needed her brief changed. She was lying in bed and had dried coffee stains and eggs on the front of her gown. The call light was draped over a radio on the bedside dresser and could not be reached. She activated the call light once it was placed into reach. At 10:41 a.m., RN 2 answered the call light. The resident indicated she needed her brief changed. RN 2 indicated she would get someone to help her, turned off the call light and walked out of the room. No other staff member was notified the resident required help. At 10:47 a.m., the call light was reactivated by the resident	F 0677	**ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)** **The facility will provide necessary services, care or assistance for dependent residents who were unable to perform activities of daily living (ADLs) including incontinent care.** · Resident O, M, E, K, J and P were not harmed **The facility will identify other situations having the potential to be affected by the same deficient practices as follows:** · All incontinent residents will be audited to ensure necessary services, care or assistance are being provided. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur.** · All nursing staff will be in-serviced on turning and repositioning residents. · All nursing staff will be in-serviced on routine toileting and PRN · All nursing staff will be in-serviced on providing incontinence care to dependent residents routinely and PRN **How the facility plans to monitor it performance to make sure solutions are sustained. The facility must**	08/21/2021

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	At 10:55 a.m., CNA 4 entered the room and asked the resident if she needed anything. The resident indicated she needed changed. CNA 4 informed the resident it would be a "little bit" and she could not change her by herself. At 10:58 a.m., the Director of Nurse (DON), entered the room. The resident informed her she needed changed. The DON turned the call light off and left the room to assist a CNA in another room. At 11:05 a.m., CNA 4 and the DON entered the room to provide care. The resident informed the DON she was "sore down there". The brief was saturated with urine and there was a large wet ring on the bottom sheet and draw sheet under her. She then indicated her "back part" was sore and that if felt "raw". When the DON attempted to wash the urine off the resident with a washcloth and water, the resident voiced that it hurt. The buttocks was red. The DON indicated it appeared to be MASD (moisture associated skin damage). As the resident was being washed she would voice "ouch", and repeated it was sore. Resident O's record was reviewed on 7/27/21 at 5:06 p.m. The diagnoses included, but were not limited to, dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 4/30/21, indicated a moderately impaired cognitive status, required extensive assistance of two for bed mobility, extensive assistance of one for toileting and hygiene, and was always incontinent of bowel and bladder. A Care Plan, dated 1/25/21, indicated incontinence of urine. The interventions included, the resident		**develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system**. · The DON or designee will audit (5) incontinent residents 3 times per week x 30 days than 2 times per week x 30 days than 1 time per week x 30 days to ensure necessary services, care and assistance is being provided. · The DON or designee will report to the QAPI Committee monthly findings from the weekly audits. This process will be monitored by the Director of Nursing Services, Administrator and Medical Director. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required	

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	was to be checked for incontinence and the brief was to be changed as needed. 2) Resident M was observed on 7/25/21: At 11:04 a.m., the resident was in bed. There was bowel movement on the upper and lower sheet. The call light was activated by the resident. At 11:15 a.m., the call light continued to be activated. No staff had been in the room to assist the resident. At 11:29 a.m., CNA 3 entered the room and provided care. The bottom sheet under the resident had a large dried urine ring and the incontinent brief was saturated. CNA 3 indicated he had last provided care to the resident at 6:30 a.m. and acknowledge the urine saturation. Resident M's record was reviewed on 7/27/21 at 2:40 p.m. The diagnoses included but were not limited to, hemiplegia and diabetes mellitus. The most recent Quarterly MDS assessment, indicated a moderately impaired cognitive status, no behaviors, required extensive assistance of one staff for bed mobility, transfers, and hygiene, dependent on one staff for toilet use, and was always incontinent of bowels and urine. A Care Plan, dated 3/4/21, indicated urinary incontinence. The interventions included, incontinence status was to be checked every two hours and incontinent care was to be completed as needed. 3) During an observation on 7/25/21 at 11:36 a.m. with the Wound Nurse present, Resident E was			

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	lying in bed. The incontinence brief and the sheet under the resident were saturated with urine. The Wound Nurse acknowledged the resident was saturated with urine. Resident E's record was reviewed on 7/27/21 at 12:47 p.m. The diagnoses included, but were not limited to, cerebral palsy. A Quarterly MDS assessment, dated 6/13/21, indicated a severely impaired cognitive status, extensive assistance with bed mobility, toileting, and hygiene, and was always incontinent of bowel and bladder. A Care Plan, dated 6/4/21, indicated urinary and bowel incontinency. The interventions included, the resident was to be checked for incontinency and incontinent care was to be provided as needed. 4) Resident K was observed on 7/25/21: At 12:30 p.m., he was lying in bed. There were dried coffee stains on the front of his gown. At 2:12 p.m., he remained in bed. The coffee stains remained on the front of his gown. He indicated he wears incontinent briefs and no one had been in today to change the brief. He had informed the staff "about two hours ago" that he needed to be changed and they had not been in to assist him. At 2:15 p.m., CNA 5 entered the room. She acknowledged the incontinent brief and the sheet under the resident was saturated with urine. The resident informed her he had not been changed all day. Resident K's record was reviewed on 7/27/21 at			

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	4:14 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A Quarterly MDS assessment, dated 7/10/21, indicated a moderately impaired cognition status, required extensive assistance of one staff for bed mobility, transfer, dressing, toileting, and hygiene, and was incontinent of bowel and bladder. A Care Plan, dated 10/7/20, indicated urinary incontinence. The interventions included, the resident was to be checked every two hours for incontinence and incontinent care was to be provided as needed. 5) During an observation on 7/25/21 at 12:18 p.m. with the Wound Nurse, Resident J was lying in bed. She indicated she had a bowel movement prior to breakfast being served and no one had been in to provide care since before breakfast. The Wound Nurse provided incontinent care. The resident had been incontinent of bowel movement, which had dried on areas of the skin. Resident J's record was reviewed on 7/27/21 at 3:21 p.m. The diagnoses included, but were not limited to, stroke. A Significant Change MDS assessment, dated 6/29/21, indicated a moderately impaired cognitive status, required extensive assistance of two staff for bed mobility, transfers, and toilet use, required extensive assistance of one staff for hygiene, and was incontinent of bowel and bladder. A Care Plan, dated 10/7/20, indicated incontinence of bowel and bladder. The interventions included, the resident was to be checked every two hours for incontinence and incontinent care was to be			

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	provided as needed. 6) Resident P was observed on 7/25/21: At 10:30 a.m., she was sitting in geri chair (reclining chair) across from the Nurses' Station. A mechanical lift pad was underneath her. She was wearing a hospital gown. At 10:45 a.m., she remained in the geri chair at the Nurses' Station. She was leaning to the left side of the chair with her left arm over the chair arm and her head leaning off the back of the chair. She remained in a night gown. At 11:21 a.m. and 12:30 p.m., she remained in the geri chair across from the Nurses' Station, and in the same position. At 2 p.m., she remained in the same position. CNA 3, indicated she was transferred from the bed to the geri chair when the breakfast trays were delivered, around 8 a.m. At 2:39 p.m., the resident was transferred by three CNA's from the geri chair to the bed. CNA 6 indicated the resident had been incontinent of urine and bowel movement. Resident P's record was reviewed on 7/27/21 at 3:55 p.m. The diagnoses included, but were not limited to, cerebral palsy. A Quarterly MDS assessment, dated 5/29/21, indicated severely impaired cognitive status, required extensive assistance of two staff for bed mobility and toilet use, dependent on two staff for transfers, and was always incontinent of bowel and bladder.			

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	A Care Plan, dated 3/22/21, indicated bowel and bladder incontinence. The interventions included the resident was to be checked for incontinence and incontinent care was to be provided as needed. This Federal tag relates to Complaint IN00358517. 3.1-38(a)(3) 3.1-38(a)(3)(A)			
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure treatments and care was provided in accordance with professional standards of practice, related to non-pressure/arterial wound care not completed as ordered by the physician for 4 of 14 residents reviewed for quality of care. (Resident B, D, H & J) Findings include: 1) During an observation with the Social Service Director present, on 7/25/21 at 10:07 a.m., Resident B was lying in bed. There was a dressing located on her left great toe with the date 7/23/21. The resident indicated she had gone to the Podiatrist. The Social Service Director acknowledged the	F 0684	**Quality of Care 483.25** **The facility will provide treatments in accordance with professional standards of practice related to non-pressure and arterial wound care as ordered by the physician.** · Resident B treatments completed per PCP order · Resident D treatments completed per PCP order · Resident H treatments completed per PCP order · Resident J treatments completed per PCP order **The facility will identify other**	08/21/2021

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	date of 7/23/21 on the dressing. During an interview on 7/23/21 at 12:07 p.m., the Wound Nurse indicated the toe dressing was to be changed daily. Resident B's record was reviewed on 7/26/21 at 12:07 p.m. The diagnoses included, but were not limited to, osteoarthritis of the knee. A Quarterly Minimum Data Set (MDS) assessment, dated 6/28/21, indicated a moderately intact cognitive status and surgical care was being completed. A Podiatrist Progress Note, dated 7/14/21, indicated a loosened nail on the left great toe and the nail had been removed. A Physician's Order, dated 6/24/21, indicated the left great toe was to be cleansed with normal saline, patted dry, then gentamycin (antibiotic ointment) was to be applied and the area was to be covered by a dry dressing every day shift. The Treatment Administration Record (TAR), dated 7/2021, indicated the treatment on 7/24/21 had not been completed and to review the Nurses' Progress Notes. There were no Nurses' Progress Notes that indicated why the treatment had not been completed. 2) During an observation on 7/25/21 at 10:25 a.m. with RN 2 present, Resident D was observed with a left great toe dressing dated 7/23/21. RN 2 indicated the dressing was to be changed every day and had not been done on 7/24/21.		**situations having the potential to be affected by the same deficient practices as follows:** · All residents with wounds will be audited to ensure wound treatments are being followed per Physician orders. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur.** · All licensed nurses will be in-serviced on following physician orders with emphasis on wound care **How the facility plans to monitor it performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system**. · The DON or designee will audit 5 residents, 3 times per week x 30 days than 2 times per week x 30 days than 1 time per week x 30 days to ensure treatment orders are being completed per physicians orders · The DON or designee will report to the QAPI Committee monthly findings from the weekly audits. This process will be monitored by the Director of	

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	During an interview on 7/25/21 at 10:57 a.m., the resident indicated he had an ingrown toenail taken out. Resident D's record was reviewed on 7/26/21 at 4:39 p.m. The diagnoses included, but were not limited to, rheumatoid arthritis An Annual MDS assessment, dated 7/14/21, indicated an intact cognitive status and applications of dressings to the feet. A Care Plan, dated 6/14/21, indicated an ingrown toenail was present. The interventions included, treatment to the area was to be completed as ordered by the Physician. A Physician's Order, dated 7/14/21, indicated the toe was to be cleansed with normal saline, patted dry, then iodosorb (antimicrobial dressing) was to be applied with a dry dressing applied to cover, every evening shift for an ingrown toenail. The TAR, dated 7/2021, indicated the treatment had been completed on on 7/24/21. 3) During an observation with the Wound Nurse on 7/25/21 at 12:15 p.m., Resident H was lying in bed. The Wound Nurse indicated there were arterial wounds on the left and right heel, which were treated with betadine and kept open to air. The left heel had a large black area on the heel. The right heel was dry scab like area. There was a very faint discoloration of betadine observed on both heels. The Wound Nurse indicated there were a few dry flakes of betadine on both of the heels. The resident indicated at the time of the observation, that the treatment to the heels was not completed often.		Nursing Services, Administrator and Medical Director. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required	

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	Resident H's record was reviewed on 7/28/21 at 2:44 p.m. The diagnoses included, but were not limited to, metabolic encephalopathy and diabetes mellitus. A Quarterly MDS assessment, dated 7/19/21, indicated moderately impaired cognition status, no behaviors, required extensive assistance for bed mobility, dressing, toileting, and hygiene, was dependent for bathing, and had four venous and arterial ulcers. A Care Plan 6/8/21, indicated arterial ulcers were present. The interventions included treatments would be administered as ordered by the Physician. The Physician's orders, dated 6/23/21, indicated, xeroform (petrolatum wound dressing) gauze to the right heel every day shift. On 7/9/19, an order was received to cleanse the ulcers with normal saline, pat dry, then betadine was to be painted on daily. The heels were to be left open to air. The TAR, dated 7/2021, indicated the right and left heel treatments had not been completed on 7/24/21. 4) During an observation on 7/25/21 at 12:18 p.m. with the Wound Nurse, Resident J was lying in a low air loss bed. There was a dressing on the right knee with the date of 7/23/21. There was brownish purulent drainage on the dressing. The left leg had a dressing, dated 7/23/21, with brown purulent drainage. Resident J indicated she picked at her scabs. The Wound Nurse indicated the resident would scratch the areas. Resident J's record was reviewed on 7/27/21 at 3:21 p.m. The diagnoses included, but were not			

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	limited to stroke. A Significant Change MDS assessment, dated 6/29/21, indicated a moderately impaired cognitive status, no behaviors, required extensive assistance of two staff for bed mobility, transfers, and toileting, required extensive assistance of one staff for hygiene. A Care Plan, dated 10/7/20, indicated the resident had scabs. The interventions included, the scabs were to be kept clean and dry. A Physician's Order, dated 7/15/21, indicated the scab on the left shin was to be cleansed with wound cleanser then bacitracin ointment was to be applied and then left open to air daily. A Physician's Order, dated 7/16/21, indicated bacitracin zinc ointment was to be applied to the right knee after cleansing daily and to be left open to air. The TAR, dated 7/2021, indicated the treatments to the left leg and right knee had been completed on 7/24/21. This Federal tag relates to Complaint IN00358517. 3.1-37			
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent			

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	pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to provide necessary treatment and services consistent with professional standards of practice to promote healing of pressure ulcers, related to treatments not completed as ordered by the Physician for 5 of 6 residents reviewed for pressure ulcers. One pressure wound had deteriorated due to increased drainage, redness, and inflammation for Resident C. (Residents C, E, G, J & K) Findings Include: 1) During an observation of Resident C, on 7/25/21 at 10:23 a.m. with RN 2 present, there were two foam dressings on the resident's inner left and right knees. The dressings were marked with the date of 7/22/21. Both dressings were saturated with dark colored drainage. RN 2 indicated the dates on the dressings were 7/22/21 and the dressings were saturated. During an observation with the Wound Nurse and RN 2 on 7/25/21 at 11:42 a.m., the wound nurse indicated the dressings were dated 7/22/21 and were saturated with drainage. She indicated the dressings were to be changed twice a day. The nurses were responsible for all treatments to be completed. The Wound Nurse measured the wounds weekly and followed up to make sure the dressings were intact. The resident was to have a	F 0686	**Treatment Services to prevent/Heal Pressure Ulcers 483.25(b)(1)(i)(ii)** **The facility will provide necessary treatment and services consistent with professional standards of practice to promote healing of pressure ulcers ensuring treatments are completed per physician order.** · Resident C treatments completed per PCP order · Resident E treatments completed per PCP order · Resident G treatments completed per PCP order · Resident J treatments completed per PCP order · Resident K treatments completed per PCP order **The facility will identify other situations having the potential to be affected by the same deficient practices as follows:** · All residents with wounds will be audited to ensure wound treatments are being followed per Physician orders. **What measures will be put into place or what systemic**	08/21/2021

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	dry dressing on the pressure wounds, not the foam dressing. RN 2 indicated there were foam dressings on the pressure areas on the bilateral inner knees. During an observation with the Wound Nurse and RN 2 on 7/25/21 at 11:52 a.m., RN 2 removed the dressing from the right inner knee and identified the drainage as purulent. The areas had been debrided by the Wound Physician and the resident was on an antibiotic. The Wound Nurse identified the peri wound as pink. RN 2 indicated the wound looked better. She then applied a new dressing to the right inner knee. RN 2 then removed the dressing from the left inner knee, which was still affixed to the skin and had slid off the pressure wound. She indicated there was a large amount of purulent drainage on the old dressing. The Wound Nurse indicated the drainage had increased and the peri wound was more red and inflamed since the last time she had observed the area. Resident C's record was reviewed on 7/26/21 at 1:05 p.m. The diagnoses included, but were not limited to, metabolic encephalopathy and functional quadriplegia. An Admission Minimum Data Set (MDS) assessment, dated 7/1/21, indicated a severely impaired cognition, required extensive assistance with activities of daily living (ADL's), frequently incontinent of bowel and bladder, had two unstageable pressure ulcers (covered with slough or necrotic tissue) on admission, non-surgical dressings and ointments were applied, and had seven days of antibiotic therapy. A Care Plan, dated 6/28/21, indicated wound management was required. The interventions		**changes you will make to ensure the deficient practice does not recur.** · All licensed nurses will be in-serviced on following physician orders with emphasis on wound care **How the facility plans to monitor it performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system**. · The DON or designee will audit 5 residents, 3 times per week x 30 days than 2 times per week x 30 days than 1 time per week x 30 days to ensure treatment orders are being completed per physicians orders · The DON or designee will report to the QAPI Committee monthly findings from the weekly audits. This process will be monitored by the Director of Nursing Services, Administrator and Medical Director. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required	

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included the treatment per Physician's Orders would be completed.

The Physician's Orders, dated 7/15/21, indicated the right and left inner knees were to be cleansed with normal saline and patted dried. Dakins Solution (solution to prevent and treat skin and tissue infections) was to be applied and dry dressings were to be used to cover the pressure ulcers twice a day and as needed.

A Physician's Order, dated 7/16/21, indicated Doxycycline (antibiotic) 100 milligrams was to be give twice a day for 14 days.

Wound cultures of the right and left inner knee pressure ulcers, dated 7/16/21, indicated many Proteus miribilis (growth of the organism).

The Wound Specialist's Progress Notes, dated 7/14/21, indicated the right inner knee measured 4 centimeters (cm) by 5 cm, was unstageable with moderate amount of serous (blood) drainage, and was covered with 80% of necrotic tissue. A surgical excision debridement was completed with 1.5 cm depth and healthy bleeding tissue observed. The left knee measured 3.5 cm by 3.5 cm, unstageable with 80% necrotic tissue. A surgical excisional debridement was completed with 1.5 cm depth and health bleeding tissue was observed.

The Wound Nurse Progress Notes, dated 7/21/21, indicated the right inner knee area was 4 cm by 5 cm. The depth was not measured and the area was unstageable. The left inner knee area measured 3.5 cm by 3.5 cm. The depth was not measured and the area was unstageable.

The Treatment Administration Records (TARs),

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	dated 7/2021, indicated the left inner knee pressure ulcer dressing change was scheduled for 8 a.m. and 5 p.m. There were initials, which indicated the dressing had been changed on 7/22/21 at 8 a.m. and 5 p.m., 7/23/21 at 8 a.m. and 5 p.m., refused at 8 a.m. on 7/24/21, and completed at 5 p.m. on 7/24/21. The TARs indicated the right inner knee pressure ulcer change was scheduled for 10 a.m. and 2 p.m. There were initials, which indicated the dressing had been changed on 7/22/21 and 7/23/21 at 10 a.m. and 2 p.m. The initials on 7/24/21 at 10 a.m. and 2 p.m. indicated the resident refused the dressing change. 2) During an observation on 7/25/21 at 11:36 a.m. with the Wound Nurse present, Resident E was lying in bed. There was an open area on the left hip with no drainage, there was no dressing on the left hip, and the brief and sheets were saturated with urine. The Wound Nurse indicated the left hip should have had a dressing covering the pressure area and acknowledged the resident was saturated with urine. Resident E's record was reviewed on 7/27/21 at 12:47 p.m. The diagnoses included, but were not limited to, cerebral palsy. A Quarterly MDS assessment, dated 6/13/21, indicated a severely impaired cognitive status, extensive assistance with bed mobility, dependent on staff for transfers, dressing, toileting, hygiene, and bathing, was always incontinent of bowel and bladder, and had had no pressure ulcers. A Care Plan, dated 6/24/21, indicated a stage 2 (partial thickness of skin loss) pressure ulcer on			

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	the left hip. The interventions included wound care would be provided as ordered by the Physician. A Physician's Order, dated 7/9/21, indicated the left hip was to be cleansed with normal saline, patted dry, triamcinolone (corticosteroid cream) to be applied and a hydrocolloid dressing (wound dressing to assist with healing) was to be used to cover the pressure ulcer. The dressing change was to be completed on evening shift on Monday, Wednesdays and Fridays. The TAR, dated 7/2021, indicated the treatment to the left hip had been completed on Friday, 7/23/21. The Wound Physician's measurements of the pressure ulcer on 7/7/21 indicated a healing wound caused from neurotic excoriation, which measured 6 cm by 6 cm by 0.2 cm on the left hip. A Wound Progress Note, dated 7/14/21, indicated the left hip measured 0.5 x 4.5 x 0.2, with no drainage. 3) During an observation with the Wound Nurse on 7/25/21 at 12:09 p.m., Resident G was lying in bed. The Wound Nurse indicated the resident had a stage 4 (full thickness skin loss) pressure area on the coccyx. The resident was observed and there was no dressing on the stage 4 area on the coccyx. The area was clean without drainage. CNA 3 was also in the room and indicated he had not checked the resident for incontinence since he started work at 6 a.m. The resident had not been incontinent. Resident G's record was reviewed on 7/27/21 at 1:43 p.m. The diagnoses included, but were not			

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	limited to, diabetes mellitus and stroke. A Quarterly MDS assessment, dated 4/8/21, indicated a severely impaired cognitive status, extensive assistance of two staff for bed mobility and toileting, dependent on two staff for transfers, extensive assistance of one staff for hygiene, and dependent on one staff for bathing, was always incontinent of urine, had an ostomy, had one stage 4 pressure ulcer, and received pressure ulcer care. A Care Plan, dated 10/7/20, indicated a pressure ulcer was present. The interventions included, wound care was to be completed as ordered by the Physician. A Physician's Order, dated 7/8/21, indicated the coccyx area was to be cleansed with normal saline and patted dry. Iodosorb (gel dressing) was to be applied and covered with a dry protective dressing every evening shift. The TAR, dated 7/2021, indicated the treatment to the coccyx had been completed on the evening shift on 7/24/21. 4) During an observation with the Wound Nurse, on 7/25/21 at 12:18 p.m., Resident J was lying on a low air loss bed. The Wound Nurse indicated there was a stage 2 pressure area on the right buttock and stage 2 areas on the right hip. The areas were observed, there was an open area on the right buttock with no dressing covering the area. There was no drainage from the the area. The right hip had a dressing over three stage 2 areas, which was dated 7/21/21. There was a hydrocolloid dressing on the left buttock. The Wound Nurse indicated the left buttock was			

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	healed and the hydrocolloid dressing had been discontinued. There was no dressing on the sacrum area. Resident J's record was reviewed on 7/27/21 at 3:21 p.m. The diagnoses included, but were not limited to stroke. A Significant Change MDS assessment, dated 6/29/21, indicated a moderately impaired cognitive status, no behaviors, required extensive assistance of two staff for bed mobility, transfers, and toileting, required extensive assistance of one staff for hygiene, dependent on staff for bathing, was always incontinent of bowel and bladder, had one stage 2 pressure area, 1 stage 3 pressure area, and received pressure ulcer care. A Care Plan, revised on 7/8/21, indicated there were pressure ulcers present and the left buttock pressure area was resolved on 7/7/21. The interventions included, the wounds would be treated as ordered by the Physician. The Physician's Orders indicated: On 8/9/20, the right buttock was to be cleansed with normal saline, patted dry and a hydrocollloid dressing was to be applied on Monday, Wednesday, and Fridays on day shift. On 7/18/21, the right hip was to be cleansed with normal saline, patted dry, triamcinolone cream was to be applied, and covered with a dry dressing every evening shift. On 3/8/21, the sacrum area was to be cleansed with wound cleanser, patted dry, skin prep was to be applied, and then covered by a foam dressing every Saturday.			

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	The TAR, dated 7/2021, indicated the hydrocolloid dressing treatment to the left buttock had been discontinued on 7/8/21, the right buttock treatment had been completed on Friday 7/23/21, the right hip treatment had been completed on July 22 and 23, 2021, and not completed on 7/24/21 due to the resident was sleeping. The treatment for the sacrum was documented as completed on 7/24/21. 5) During an observation, with the Wound Nurse, on 7/25/21 at 12:30 p.m., Resident K was lying in bed. There was a dressing on the left heel dated 7/21/21. There was bloody/purulent drainage on the dressing. The right heel was scabbed with no dressing on the heel. The Wound Nurse indicated the right heel was to be left open to air. Resident K's record was reviewed on 7/27/21 at 4:14 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A Quarterly MDS assessment, dated 7/10/21, indicated a moderately impaired cognitive status, required extensive assistance of one staff for bed mobility, transfers, toilet use, dressing, and hygiene, was frequently incontinent of bowel and bladder, had two stage three (full thickness skin loss involving subcutaneous tissue damage) pressure ulcers, and received pressure ulcer care. A Care Plan, dated 12/15/20, indicated pressure ulcers were present. The interventions included, treatments would be administered as ordered by the Physician. Physician's Orders, dated 7/14/21, indicated to cleanse the left heel with normal saline, pat dry, oil emulsion was to be applied with an island gauze with border, every Monday, Wednesday and			

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	Friday on day shift. The right heel was to be cleansed with betadine, patted dry, betadine to be applied, and leave open to air. The TAR, dated 7/2021, indicated the left heel treatment had been completed on Wednesday, 7/21/21 and not completed on Friday, 7/23/21. The right heel treatment had not been completed on 7/23/21 and 7/24/21. This Federal Tag relates to Complaint IN00358517. 3.1-40(a)(2)			
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to provide supervision to prevent an elopement of a cognitively and mentally impaired resident, who had a court appointed Guardianship, from signing himself out of the facility. The resident was out of the building for 5.5 hours before he was identified as missing. The Police were notified and a Silver Alert was issued. The whereabouts were unknown to the facility and the resident was found in a neighboring state at a hotel close to an airport 4.5 days later. The Hotel where the resident was found was 30-31 miles from the facility. The Guardianship papers were not at the facility at the time of the	F 0689	Past noncompliance: No POC required.	08/06/2021

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elopement, though the facility was aware of the Guardianships, for 1 of 3 residents reviewed for supervision. (Resident Q)

The immediate jeopardy began on 7/14/21 when the facility allowed the resident to sign himself out of the facility and the facility was unaware of the resident's whereabouts. The resident, who walks with a walker, walked to a local gas station and was transported to a hotel in neighboring state by strangers and was found after a Silver Alert was issued on 7/14/17on 7/17/21 at the hotel. The Director of Nursing (DON) and the Regional Clinical Director were notified of the immediate jeopardy at 1:26 p.m. on 7/26/21. The immediate jeopardy was removed, and the deficient practice corrected, on 7/23/21, prior to the start of the survey and was therefore Past Noncompliance.

Finding includes:

An Indiana Department of Health (IDOH) Reportable Incident Form, dated 7/15/21, indicated the incident occurred on 7/14/21 at 4:01 p.m. Resident Q had signed himself out of the facility to eat breakfast with his brother. The resident had not returned to the facility and the brother was notified. The brother had indicated the resident had not been with him. The Police were then notified.

Resident Q's record was reviewed on 7/25/21 at 2:47 p.m. The diagnoses included, but were not limited to, Parkinson's disease, bipolar, and schizophrenia. The admission into the facility occurred on 7/9/21.

A Preadmission Screening and Resident Review, dated 9/23/19, from a past admission and remained in the electronic record, indicated the mother had

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	been appointed as his legal guardian. A confidential fax from the discharging Hospital to the facility, dated 6/22/21, indicated a Patient Information Form was faxed to the facility and the brother was identified as the Guardian. The Hospital History and Physical, dated 6/10/21, indicated the brother and the mother were both Court Appointed Guardians. Court appointed Guardianship papers, dated 4/7/16, scanned into the record on 7/21/21, indicated the mother and brother were appointed as Guardian. The Admission Packet forms, dated, 2/12/20 and signed on 7/9/21, were all signed by the brother. During an interview on 7/26/21 at 8:57 a.m., the Admission's Coordinator, indicated the brother had signed all the admission paperwork. She indicated the date on the Admission Agreement was 2/12/20 due to a past admission and he was still "in the system". The admission paperwork was signed on 7/9/21. The brother had informed her at the time of the paperwork he was either the Power of Attorney or the Guardian. She had asked the brother for this paperwork prior to the admission and at the time of the admission. He had indicated the the paperwork was not with him. He was asked again a few days later. The validation of the Power of Attorney and/or Guardianship could not be completed without the paperwork. It was the responsibility of the "Admission's Team", to obtain all paperwork. A, "Care Plan Recommendation and Minimum Data Set Components" form, dated 7/12/21, indicated there was mild-moderate cognitive			

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	impairment and modified independence with daily decision making skills. A Care Plan, dated 7/12/21, indicated the cognitive function of the resident was impaired. The interventions included changes in cognitive function, specifically in decision making ability, memory, and recall were to be documented and reported to the Medical Provider. The Care Management Team Meeting note, dated 7/12/21 at 9:48 a.m., indicated the Executive Director (ED), Director of Nursing (DON), Resident Assessment Coordinator, Social Service, and direct care staff were in attendance. The resident had been living at home and barricaded himself in the bedroom, was not eating, had weight loss, refused showers, and would not allow the family to help. The resident's mother was a Court Appointed Guardian. During an interview on 7/26/21 at 12:50 p.m., the DON indicated she had not been at the Care Management Team Meeting and was unaware the resident had a Guardian until the incident occurred. The Physician's Orders indicated there was no order obtained for the resident to leave the facility with or without supervision. A Nurse's Progress Note, dated 7/14/21 at 9:30 a.m. (documented on 7/14/21 at 4:20 p.m.) indicated he had signed himself out of the facility in the morning. The Physician had been notified. The facility was waiting on him to return to the facility. Information was passed on to the Evening Nurse. A facility Sign Out form, indicated the resident			

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	had signed himself out on 7/14/21 at 9:30 a.m. and had not signed self back into the facility. A Nurse's Note, dated 7/14/21 at 3:45 p.m. (late entry on 7/14/21 at 9:34 p.m.) indicated he had not yet returned to the facility. The family, Supervisor, and DON had been notified. There were no further Nurses' Progress Notes which indicated the resident was still missing from the facility. A Nurse's Progress Note, dated 7/17/21 at 7:29 p.m., indicated the resident was re-admitted from the Hospital. A time line for the incident, provided by the DON on 7/26/21 at 9:09 a.m., indicated on 7/14/21 at 9:30 a.m. the resident was in the front of the building in a wheelchair and had informed the Receptionist he was leaving for breakfast with his brother. The Receptionist notified LPN 1 and the Medical Records Nurse came to the front of the building with the Sign Out Form and he signed himself out of the facility. He then used a walker and walked outside of the facility. On 7/14/21 at 2 p.m., LPN 1 had noticed he had not returned to the building and notified the brother who indicated the resident had not been with him. The mother was then notified and stated she had not seen the resident. At 4 p.m., the Unit Manager was notified and notified the DON. At 4:15 p.m. the building was searched. On 7/14/21 at 4:30 p.m., the DON had notified the brother, who indicated he does not know where the resident was and had not heard from him nor seen him. He stated he was the Court Appointed Guardian and had not brought the papers in to the			

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	facility yet. He stated he was going to go to the local Police Department and would bring the Guardian papers to the facility. On 7/14/21 at 4:15 P.M., the facility notified the local Police Department. The Local Police Department Incident Report, indicated the facility notified them on 7/14/21 at 5:59 p.m. and an officer was dispatched. The DON had advised the Officer the resident had signed himself out at 10 a.m. on 7/14/21 and had not returned to the building. The DON indicated he had a Power of Attorney and should not have been able to sign himself out. The Power of Attorney had requested the resident be reported missing. During an interview on 7/26/21 at 11:10 a.m., the DON indicated he was brought back to the facility on 7/17/21. The Police had said he was found in a neighboring State at a hotel near the airport. He had been at the gas station and informed a patron at the station he had been abandoned and needed to get to the airport so he could go to California. The Patron at the gas station gave him a ride to the hotel. Once he was found, the brother picked him up and transported him to the Hospital to evalutated for medical clearance for him to return to the facility. During an interview on 7/26/21 at 4:50 p.m., a Detective at the Local Police Department indicated the resident was found in a hotel near an airport in a neighboring state. They had received a call from the facility at 5:59 p.m. on 7/14/21 and a Patrolman was sent to he facility. A Silver Alert was issued. A patron at the gas station had given him a ride after he had told him he needed to get to California. The resident had been found on			

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	7/17/21 between 12 and 2 p.m. A camera timeline, dated 7/14/21, indicated at 9:07 a.m. the resident walked down the sidewalk with the walker and sat in the wheelchair in the shade at the front entrance in the parking lot. At 9:14 a.m., the Medical Records Nurse approached him and he signed himself out, 9:15 a.m., the Medical Records Nurse walks back into the building. At 9:21 a.m., he walks in the mulch, standing by the tree and had not used his walker. At 10:07 a.m., he gets up from the wheelchair, used his walker and walked to the northeast side of the parking lot. At 10:08 a.m. he was at the exit of the parking lot and the walker was being used. Signed statements from staff indicated: On 7/14/21, the Receptionist indicated around 9:30 a.m. he stated he was going to breakfast with his brother and asked if he could wait for him in front of the building. He was asked if he checked out at the Nurses' Station and he said yes. His yes was not very convincing. He was let out the front door and the Nurses' Station was notified. The resident had not signed out at the Nurses' Station. They were informed the resident was at the end of the sidewalk, sitting in the wheelchair, and waiting on his brother to go to breakfast. On 7/14/21, LPN 1 indicated she had received a phone call from the Receptionist, stating the resident was outside in the wheelchair at the corner of the sidewalk around 9:30 a.m. The Medical Records Nurse was asked to to take the Sign Out Form to him so he could sign himself out. Rounds were completed at 3 p.m. and the resident had not returned to the facility. His cell phone, mother, and brother was called. A voicemail was left on the cell phone to return to			

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	the facility. The Unit Manager was also notified. On 7/14/21, the Unit Manager indicated she arrived at the building at 8:30 a.m. and was informed later by the "Floor Nurse", the resident had went out on pass at 9:30 a.m. The Resident Information Form (facesheet) indicated he was responsible for himself, his mother and brother were emergency contacts. A signed statement from the Admissions Director, dated 7/15/21, indicated the admissions process was completed with the brother on 7/9/21. The resident was present during the process. During the conversation the brother indicated he was Power of Attorney and would provide the paperwork. The resident was informed he could go out on pass with his brother though he needed to be signed out prior to leaving and could only leave facility property when accompanied by his brother. During an interview on 7/26/21 at 9:31 a.m., the Corporate Regional Clinical Director indicated through their investigation, this was determined to be a leave of absence. There had been no Guardian limitations in place and the brother had not brought the Guardianship papers into the facility. During an interview on 7/26/21 at 9:38 a.m., the Unit Manager indicated LPN 1 had notified her around 3 p.m. on 7/14/21 and she had notified the DON around 3:30 - 4 p.m. She had looked at the face sheet when he went out and it had indicated he was responsible for himself. There was nothing that indicated he had a Power of Attorney. At 9:53 a.m. on 7/26/21, the DON presented the facesheet at the time of the incident, which			

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	indicated the resident was his own financial agent. Emergency contact number one was his brother and number 2 was his mother. During an interview on 7/26/21 at 11:01 a.m., RN 2 indicated she was told by LPN 1 he was missing when she came into work that later evening. The admission documentation indicated he had severe schizophrenia and was not able to make safe judgements or decisions. She questioned why he was able to sign himself out of the building. During an interview on 7/26/21 at 12:47 p.m., the Resident's Guardian indicated when the admission paperwork was completed, he had informed the facility he was the Guardian. He was never asked for the paperwork and had assumed they still had the paperwork from the past admissions. He was never asked about the paperwork until 7/13/21, when the facility called him and he informed them he would bring the paperwork in to the facility on 7/14/21. A facility policy, dated 7/1/16, titled, "Resident Leave of Absence (LOA)", received from the DON as current, indicated, "...a resident/patient who is cognitively intact with independent decision making with a physician's order may sign themselves out for a LOA...For residents/patients that sign out for a LOA the resident/patient/family/responsible party will indicate the anticipated time of return at the time they sign out...Obtain a physician's order for the resident/patient to leave the facility with or without supervision...Notify the Executive Director (ED) if unable to contact the resident/patient or family/responsible party, or if they refuse to return." The past noncompliance immediate jeopardy			

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	began on 7/14/21. The immediate jeopardy was removed and the deficient practice corrected by 7/23/21 after the facility implemented a systemic plan that included the following actions: the resident was assessed for elopement and a Wanderguard bracelet had been applied to the right ankle, all staff were inserviced on the Leave of Absence, Elopement Management, and Elopement Prevention policies. The Admission's Director had training for clinical review, requesting all Power of Attorney/Guardianship paperwork from the Hospital prior to admission or from the family/Guardian prior to admission or on admission, and ensuring all have been updated in the medical record. Elopement/Wandering assessment will be completed on all residents on admission and with significant changes. Photographs and resident information will for residents at risk for elopement will be kept at the Nurses' Station and Reception Desk. Staff were interviewed and able to explain the policies and procedures. Binders were located at the Nurses' Desk and Receptionist Desk, which included the other residents who were at risk for elopement. All charts were reviewed for accurate information on the Facesheet for status of Power of Attorney/Guardianships. This Federal tag relates to Complaint IN00358517. 3.1-45(a)(2)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical,			

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	mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, record review and interview, the facility failed to ensure sufficient nursing staff was present to provide timely and complete activities of daily living (ADL's) care, responding to call lights, and wound/pressure/arterial sore treatments. This had the potential to affect 67 residents who reside on the West Unit. Findings include: Entrance into the facility occurred on 7/25/21 at 9:45 a.m. The West Unit was staffed with one CNA and a Restorative CNA who had been pulled from her duties. There were two Nurses' on the unit. The CNA's were picking up breakfast trays and the Nurses' were passing medications.	F 0725	**Sufficient Nursing Staff 483.35(a)(1)(2)** **The facility will ensure sufficient nursing staff are present to provide timely and complete ADL care.** · All 67 resident that reside on the west unit were not harmed · No other residents have sustained harm while residing at the facility. **The facility will identify other situations having the potential to be affected by the same deficient practices as follows:** · The facility has implemented a recruiting initiative for licensed nurses, QMAs, and	08/21/2021

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	CNA 3 was interviewed at the time of the initial observation and indicated he was the only CNA on the Unit until the Restorative CNA came to the Unit. The other CNA's scheduled had not come in as scheduled. Most residents have been left in bed except most the ones who are dependent on staff for eating. They were attempting to check the residents for incontinency. During an interview on 7/25/21 at 9:52 a.m., the Social Service Director indicated the Director of Nursing (DON) was aware of the staffing shortage and had text her yesterday and asked her to come and help because the facility was going to be short on staff. A Facility Census sheet was reviewed on 7/25/21 at 9:52 a.m., there were 67 residents on the West Unit. 1) Observations and interviews on 7/25/21 were as follows: At 9:56 a.m., there were 37 residents who remained in bed. At 9:58 a.m., the Social Service Director informed the DON a IDOH Survey was in process. At 9:59 a.m., the Maintenance Director was observed passing ice water to the residents. He indicated he was the Manager on Duty and had been at the facility since 8 a.m. He was asked by the Executive Director to help out since the facility was going to be low on staff this week-end. At 10:04 a.m., Activity Aide 7 entered the West Unit and indicated on 7/24/21 the DON had asked if she could come in early to assist on the Unit.		C.N.A.s. · The facility is employing agency staff to maintain appropriate staffing numbers. · The facility will also offer pick-up bonuses for staff. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur.** · All nursing staff will be in-serviced on ADL Care to include responding to call-lights, wound and pressure/arterial wounds. **How the facility plans to monitor it performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system**. · The ED or designee will hold a staffing meeting 5 times weekly x 90 days to ensure sufficient nursing staff are present to provide timely ADL care, call light response and wound care/treatments. · The ED or designee will report to the QAPI Committee monthly findings from the weekly audits. This process will be monitored by the Director of Nursing Services, Administrator	

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	She was not a CNA. At this time she was assisting the residents to an activity. At 10:28 a.m., RN 1 indicated there were supposed to be three Nurses scheduled. At 10:37 a.m., CNA 4 indicated she was a Restorative Aide and had been pulled off restorative to assist on the Unit. At 10:58 a.m., the DON entered the West Unit. At 1:59 p.m., CNA 8 indicated this was his normal day off and was called around 10:30 a.m. and was asked to come in to assist by the DON. CNA 3 was interviewed at 2 p.m., and indicated there were 21 resident who were mechanical lifts and required two staff to transfer and 30 residents who required extensive to dependent care for ADL's, on the West Unit. 1) Review of the schedule for the West Unit indicated on 7/25/21 at 5 p.m. the following staff was scheduled: On 7/24/21, Day Shift there was 2 Nurses, and 2 CNA's scheduled. 1 CNA was a no call/ no show, the DON worked and another staff member came in at 12 p.m. There was a nurse and and QMA on Evening Shift, and 3 CNA's with one scheduled to leave at 8 p.m., 1 Nurse on Night Shift, and 2 CNA's. On 7/25/21, Day Shift there were 2 Nurses' scheduled and 3 CNA's. 2 of the CNA's were a no call no show. The Restorative Aide was switched to be a CNA and a CNA come in at 11 a.m. The Evening Shift there was 1 Nurse and 1 QMA, 3 CNA's the full shift and 1 CNA from 2 p.m. to 8		and Medical Director. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required.	

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	p.m. The Night Shift had 1 Nurse and 3 CNA's. 2) Confidential Staff Interviews indicated it was difficult to care for the amount of residents on the West Unit and treatments/dressings are not completed due to shortness of staff. 3) Resident N's call light was activated on 7/25/21 at 10:30 a.m. The call light was answered at 11:18 a.m. He indicated the call light had been on for an hour and he needed a pain pill. A pain pill was given to the resident at 11:24 a.m. During an interview with Resident N on 7/25/21 at 1:56 p.m., he indicated long response time to call lights occurred frequently. He has spoke with the Administrator about this. He indicated he has used his phone to call the station to get help and has had to wait an 1.5 hours for his call light to be answered. Resident N's record was reviewed on 7/27/21 at 3:35 p.m. The diagnoses included, but not limited to, diabetes mellitus. A Quarterly Minimum Data Set assessment, dated 6/23/21, indicated his cognition was intact. 4) The Resident Council President was interviewed on 7/25/21 at 3:10 p.m. She indicated there have been several concerns over the lack of staff brought to her attention. Call lights not answered timely and care concerns. The Administrator had been made aware. 5) Cross reference F677 for ADL's related to incontinence care, hygiene, positioning, and call light response. 6) Cross reference F684 for quality of care related			

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	to, wound care not completed as ordered. 7) Cross reference F686 for pressure/arterial ulcer care, related to, treatments not completed as ordered. 8) Cross reference F839 for unqualified staff, related to, uncertified staff provided ADL care to a resident. During an interview on 7/27/21 at 3:50 p.m., the DON indicated the policy was to call in Management and to use anyone who is trained. Have contracts with 3 agencies. One of the no call/no shows was agency on 7/25/21, and one no call/no show was facility staff. The Emergency Staffing Policy, dated 8/18/17, and received from the DON as current indicated The type of staff members needed to provide support and care for resident would be identified. Staffing was based on the resident population and needs for care and support required. A facility policy, dated 6/9/17, titled, "Nurse staffing information", received by the Regional RN, indicated, the policy of the facility was to provide resident centered care that met the psychosocial, physical, and emotional needs and concerns of the residents. The facility would provide the sufficient number of staff to care for the resident population. This Federal tag relates to Complaint IN00358517. 3.1-17(a)			
F 0839 SS=D Bldg. 00	483.70(f)(1)(2) Staff Qualifications §483.70(f) Staff qualifications.			

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	§483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. Based on observation and interview, the facility failed to ensure a staff member who was providing care to a resident was certified by the Indiana Department of Health (IDOH), related to the Social Service Director providing incontinent care for an extensive to dependent resident, for 1 of 5 employees observed providing care to residents. (Social Service Director and Resident B) Finding includes: During an observation on 7/25/21 at 10:07 a.m., Resident B activated the call light and informed the Social Service Director she had been incontinent of bowel movement. The Social Service Director obtained supplies, removed the brief and provided incontinent care. Resident B's record was reviewed on 7/26/21 at 12:07 p.m. The diagnoses included, but were not limited to, osteoarthritis of the knee A Quarterly Minimum Data Set assessment, dated 6/28/21, indicated a moderately impaired cognitive status, required extensive assistance of one staff for bed mobility and hygiene. During an interview on 7/25/21 at 10:14 a.m., the Social Service Director indicated she had been a CNA, though she was not sure if her Certification was current.	F 0839	**Staff Qualifications 483.70(f)(1) (2)** **The facility will ensure staff members who provide care to residents are certified/licensed to do so** · Resident B was not harmed · Social Service Director educated on only providing care within her scope of practice. **The facility will identify other situations having the potential to be affected by the same deficient practices as follows:** · The facility has implemented a recruiting initiative for licensed nurses, QMAs, and C.N.A.s. · The facility is employing agency staff to maintain appropriate staffing numbers. · The facility will also offer pick-up bonuses for staff. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur.** · Social Service Director educated on only providing care within her scope of practice.	08/21/2021

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	Review of the Social Service Director's CNA Certificate on 7/25/21 at 1 p.m., indicated the Certificate expired on 10/17/20. This Federal tag relates to Complaint IN00358517. 3.1-14(s)		**How the facility plans to monitor it performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system**. · The ED or designee will hold a staffing meeting 5 times weekly x 90 days to ensure sufficient nursing staff are present to prevent uncertified/unlicensed staff are not providing care out of their scope of practice. · The ED or designee will report to the QAPI Committee monthly findings from the weekly audits. This process will be monitored by the Director of Nursing Services, Administrator and Medical Director. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility			

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	155218	A. BUILDING 00 B. WING	07/27/2021

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	itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-			

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	(i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on record review and interview, the facility failed to ensure a medical record was complete and accurate, related to information about a resident's court appointed Guardianship not updated on the Resident Information Sheet and the papers for the Guardianship not obtained and placed in the record, for 1 of 14 resident records reviewed. (Resident Q) Finding includes: Resident Q's record was reviewed on 7/25/21 at 2:47 p.m. The diagnoses included, but were not limited to, Parkinson's disease, bipolar, and schizophrenia. The admission into the facility occurred on 7/9/21. A Preadmission Screening and Resident Review, dated 9/23/19 from a past admission and remaining in the electronic record, indicated the mother had	F 0842	**Resident Records 483.20(f)(5), 483.70(i)(1)-(5)** **The facility will ensure medical records are accurate related to court appointed guardianship and updated on the resident's information sheet.** · Resident Q legal guardian paperwork has been given to the facility and resident information sheet has been updated to reflect legal guardianship **The facility will identify other situations having the potential to be affected by the same deficient practices as follows:** · All residents with legal guardian ship will be audited to ensure the resident information sheet has been updated to reflect	08/21/2021

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	been appointed as his legal guardian. A confidential fax from the discharging hospital to the facility, dated 6/22/21, indicated a Patient Information Form was faxed to the facility and the brother was identified as the Guardian. The Hospital History and Physical, dated 6/10/21, indicated the brother and the mother were both Court Appointed Guardians. The Admission Packet forms, dated, 2/12/20 and signed on 7/9/21, were all signed by the resident's brother During an interview on 7/26/21 at 8:57 a.m., the Admission's Coordinator, indicated the brother had signed all the admission paperwork. The brother had informed her at the time of the paperwork he was either the Power of Attorney or the Guardian. She had asked the brother for this paperwork prior to the admission and at the time of the admission. He had indicated the the paperwork was not with him. He was asked again a few days later. The Care Management Team Meeting note, dated 7/12/21 at 9:48 a.m., indicated the Executive Director (ED), Director of Nursing (DON), Resident Assessment Coordinator, Social Service, and direct care staff were in attendance. The resident's mother was a Court Appointed Guardian. An Indiana Department of Health (IDOH) incident report, dated 7/15/21, indicated the resident had signed himself out of the facility and had not returned to the facility. During an interview on 7/26/21 at 11:10 a.m., the		legal guardianship and paperwork has been obtained by facility. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur.** · The Admission's Director will be in-serviced on obtaining legal guardian paperwork and ensuring the resident information sheet has been updated to reflect legal guardianship **How the facility plans to monitor it performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system**. · The ED or designee will audit all admissions weekly x 90 days to ensure any resident with a legal guardian is reflected on the resident information sheet · The ED or designee will report to the QAPI Committee monthly findings from the weekly audits. This process will be monitored by the Director of Nursing Services, Administrator and Medical Director. The QAPI committee will determine when 100% compliance is achieved and if further monitoring is required.	

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	Director of Nursing (DON) indicated he was brought back to the facility on 7/17/21. The Police had said he was found in a neighboring State at a hotel near the airport. He had been at the gas station and informed a patron at the station he had been abandoned and needed to get to the airport so he could go to California. The Patron at the gas station gave him a ride to the hotel. Once he was found, the brother picked him up and transported him to the hospital to evaluated for medical clearance for him to return to the facility. A signed statement, dated 7/14/21, by the Unit Manager indicated she arrived at the building at 8:30 a.m. and was informed later by the "Floor Nurse", the resident had went out on pass at 9:30 a.m. The Face sheet had indicated he was responsible for himself, his mother and brother were emergency contacts. During an interview on 7/26/21 at 9:38 a.m., the Unit Manager indicated LPN 1 had notified her around 3 p.m. on 7/14/21 and she had notified the DON around 3:30 - 4 p.m. She had looked at the face sheet when he went out and it had indicated he was responsible for himself. There was nothing that indicated he had a Power of Attorney. At 9:53 a.m. on 7/26/21, the DON presented the Facesheet at the time of the incident, which indicated the resident was his own financial agent. Emergency contact number one was his brother and number 2 was his mother. During an interview on 7/26/21 at 12:47 p.m., the Resident's Guardian indicated when the admission paperwork was completed, he had informed the facility he was the Guardian. He was never asked for the paperwork and had assumed they still had the paperwork from the past admissions. He was			

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	never asked about the paperwork until 7/13/21, when the facility called him and he informed them he would bring the paperwork in to the facility on 7/14/21. The Court appointed Guardianship papers, dated 4/7/16, was not scanned into the record until 7/21/21, and it indicated the mother and brother were appointed as Guardian. This Federal tag relates to Complaint IN00358517. 3.1-50(a)(1) 3.1-50(a)(2)			