STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW ALBANY NURSING AND REHABILITATION CENTER	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 IN00342862. Complaint IN00342862 - Substantiated. Federal/State deficiencies related to the allegations are cited at F0921, F0842 and State Residential Finding related to the allegations is cited at R00148. Unrelated deficiencies are cited Survey dates: February 22, 23, and 24, 2021. Facility number: 001145 Provider number: 155616 AIM number: 200120200 Census Bed Type: SNF/NF: 61 Residential: 6 Total: 67 Census Payor Type: Medicare: 3 Medicaid: 56 Other: 2 Total: 61 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 8, 2021.	F 0000		
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation			

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

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	The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on record review and interview, the facility failed to ensure residents were free from resident to resident physical abuse did not occur for 3 of 3 residents reviewed for abuse. (Resident C, H, and J). Findings include: 1. a. The clinical record for Resident C was reviewed on 2/22/21 at 10:04 a.m. The resident's diagnoses included, but were not limited to, psychotic disorder with delusion due to known physiological condition, altered mental status, schizophrenia, type 2 diabetes mellitus, and major depressive disorder. The care plan, last revised 12/28/20, indicated the Resident was a level 2 and does not require specialized services. Resident was mentally ill and had the diagnosis of: Schizophrenia, Paranoid Type. The care plan, last revised on 4/13/20, indicated the resident presented with primary diagnosis of: Schizophrenia-paranoid type, Depression, and Personality Disorder. He may exhibit any or all	F 0600	F-600- Free from Abuse and Neglect (D) Residents C, J, and H, are currently free of resident to resident physical abuse. No further occurrences have been noted. All three residents have a similar type of mental illness diagnosis. All residents reside on different halls as to decrease the risk of interactions. All residents are at risk for this alleged deficient practice 100% Audit of care plans completed by MDS coordinator, social services director, Director of Nursing, and Designees for accurate interventions for aggression and behaviors. Behaviors will be care planned and new interventions will be documented and implemented for that behavior. Care plans, behaviors, and interventions will be updated daily during clinical morning meeting.	03/26/2021

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	of the following moods and behaviors: Repetitive, Yells out, Can be easily agitated, calls staff names, hits self, Keeps urinal on over-bed table where he places his food, urinating in cup and then drinking out of it later in the day, Preaching loudly in hallway, Staying up all night incontinent and refuses to allow staff to change linen or provide care, Refusing to shower or to shave, Refusing to transfer, Hiding Bowel Movements, laying in his feces and refusing to allow staff to change him. Continues to refuse care, having word salad and delusional behaviors. The Brief Interview For Mental Status (BIMS), dated 2/9/21, indicated "...res triggered Hallucinations & delusional bx [behaviors]." The review of the State of Indiana Certification of PASARR (Pre-Admission Screening and Annual Resident Review/MI (Mental Illness), dated 5/6/15, indicated upon admission, "...He had been sexually inappropriate with female staff and was being followed by Behavioral Health. On February 4, 2014 thru February 20, 2014 he was admitted to ... [name of local hospital] due to assaulting a staff member. Has history of assaulting staff at nursing facility." The Physician's Report, dated 7/24/20, "... [resident C's name] has been Schizophrenic. Since his early 20's. Very paranoid & delusional. States frequently he hears from God to hurt others... He makes unsafe decisions which have resulted injury ...He needs constant supervision ...When out of his familiar surroundings res [resident] is easily agitated with increased behaviors." b. The Incident Report, dated 12/2/20, indicated the resident stated he was told by 'God' to kick		-Behavior sheets will be completed to reflect any aggression the resident may be exhibiting, triggers will be documented, and new interventions will be put in place for that behavior. -Residents who exhibit behaviors or triggers will have close supervision and documentation of those behaviors and triggers. Supervision will continue until the resident has been evaluated by the Medical Director or Psych services and/or the IDT determines otherwise. -All facility nursing staff will attend an in-service on documentation of behaviors and the appropriate interventions. They will be in-serviced and shown how to recognize possible triggers to behavior, note the trigger, observe the resident for behaviors when triggers are present, and how to properly document those triggers and behaviors on a behavior sheet. Completing the pink behavior sheets properly and turning them in to the proper staff. In service will be done by DON or Designees. -Documentation Audit Schedule to be completed by 3/26/2021- Documentation audits of care plans, behavioral sheets, behaviors, and new interventions are to be completed in the following timeframe: Three times a week for one month, weekly for two months, semi-monthly for two	

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	[Name of Resident J] multiple times in legs. [Name of Resident J] took his cane and hit [Name of Resident C] multiple times in groin and abdominal region. c. The Incident Report dated, 1/26/21, indicated Resident C and Resident H were sitting in the Assisted Living Dining Room, when Resident C came up behind Resident H and hit him twice in the back of his head. Resident C's Social Services note, dated 12/2/20 at 12:05 p.m., indicated The Social Service Director was called to the unit because Resident C kicked Resident J multiple times and then turned around to leave as staff were coming, but turned around again and kicked Resident J again. Resident C indicated he had a fear and God had told him to overcome his fears and not be a "p---y", so he had to hurt someone. When asked if he would do it again his response was yes that he was going to do it again. Resident C had a history of not quitting and going back to the same resident that he had picked out. The Nurse Practitioner's note, dated 7/9/20 at 2:34 p.m., indicated the Nurse Practitioner was in the facility on this day and Resident C was seen due to the resident's manic mood. The Nurse's note, on 12/10/20 at 1:00 p.m., indicated Resident C arrived at the facility, from a local hospital, after having the aggressive behaviors. The clinical records lacked documentation of any new interventions of aggression or of the resident being monitored for physical aggression toward others.		months, then once monthly. Audits will be completed by the Director of Nursing or her designees. All findings will be noted and brought to QAPI for review until 100% compliance has been achieved.	

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	During an interview, on 2/24/21 at 11:30 a.m., the Director of Nursing indicated when the resident starts talking to and about God his behavior can become aggressive. She thought the altercation with Resident H was due to religious beliefs. She did not know the reason why the resident had the altercation with Resident J. He just said the Lord told him to hurt someone. During an interview on 2/24/21 at 11:47 a.m., LPN (Licensed Practical Nurse) 10 indicated you never know what Resident C will be like with his behaviors. Sometimes he was aggressive. Then he will say that Jesus told him to do that. He had hallucinations about fighting. He had been like that all of the time he had resided at the facility. He had gotten more aggressive lately. He will be fine one minute, then he does something. He cussed staff out yesterday. The 1st incident occurred during an activity in the dining room. Resident C wasn't doing the activity, but wheeled up and hit Resident J. The 2nd incident occurred in the dining room. Resident H was just eating his meal and not saying anything to Resident H when he hit him in the back of the head. The review on 2/24/21 at 11:03 a.m., of the Abuse & Neglect Policy, revised on 8/5/16, included, " ...Prevention ...The facility will involve qualified mental health professionals to help the staff manage difficult or aggressive residents. Staff will be deployed in sufficient numbers on each shift to meet the needs of the residents. Assigned staff will have knowledge of the individual's residents' care needs ...The clinical staff will assess, care plan and monitor residents with needs and behaviors that might lead to conflict or neglect, such as residents with a history of aggressive behaviors, resident who			

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	have behaviors such as entering other residents' rooms, resident with self-injurious behaviors, residents with communication disorders, residents that require heavy nursing care and/or totally dependent on staff. The staff will identify events, occurrences, patterns, and trends that may constitute abuse and to determine the direction of the investigations ..." 3.1-27(a)(1) 3.1-27(b)			
F 0657 SS=D 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			

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	interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview, and record review, the facility failed to ensure a resident's plan of care was updated for 1 of 10 residents reviewed for care plan revisions. (Resident C) Findings include: The clinical record for Resident C was reviewed on 2/22/21 at 9:30 a.m. Diagnoses included, but were not limited to, psychotic disorder with delusions due to physiological condition, Altered mental status, schizophrenia, and major depressive disorder. The Quarterly MDS (Minimum Data Set) assessment, dated 2/9/21, indicated the resident was moderately cognitively intact. The incident report, dated 1/26/21 at 11:01 a.m., indicated, "... Both residents were sitting in AL [assisted living] dining room when [Name of Resident C] came up behind [Name of Resident H] and hit him twice in the back of his head..." The care plan, dated 8/16/14 and last revised on 1/13/21, lacked documentation of any new interventions or revisions after an incident of physical aggression. During an interview, on 2/22/21 at 11:10 a.m., the Social Service Director indicated, Resident C heard from God. His behaviors had increased since the death of a family member about a year ago. During an interview, on 2/24/21 at 11:30 a.m., the DON (Director of Nursing) indicated, that	F 0657	F-657 Care Plan Timing and Revision Resident C's Care Plan has been updated. All residents are at risk for this alleged deficient practice. A 100% audit of residents' care plans was completed to verify that there were no other care plans that lacked updates for interventions, none were found. Audit completed by MDS and Social Services Director. -Education provided for MDS coordinator and SSD by 3/26/21. MDS is the back-up for SSD if SSD is off work or out of the building. The DON or her designee will be the back-up for the MDS if the MDS is off or out of the building. Education completed by Director of Nursing. -Inservice completed for all nursing staff educating them on Care Plan updating process when changes occur such as – fall, behavior, medication changes, and implementing interventions. How to properly document on BOP sheets, pink behavior sheets, incidents reports, and notes on those incidents/behaviors. In-services completed by 3/36/2021. In service completed by DON or Designee. -Incidents, behavior, falls, and all other items requiring care plans to	03/26/2021

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	anytime there was an incident or any kind of behaviors by a resident the care plan needed to be revised and updated with new interventions. During an interview, on 2/24/21 at 11:41 a.m., LPN (Licensed Practical Nurse) 11 indicated usually after an incident occurred, she guessed it was discussed at the morning meeting by management, but she wasn't sure when the care plans were updated and revised. During an interview, on 2/24/21 at 12:00 p.m., the MDS Coordinator indicated, the care plans were reviewed and updated quarterly. If there were any changes or incident in behaviors the care plan would be updated and revised. A new intervention would be added each time to the care plan. The floor staff would fill out a behavior sheet and then it goes to the DON and Social Services. They would update and revise the care plan with new interventions in the morning meeting. There should be a new intervention after any change. On 2/24/21 at 11:10 p.m., the DON provided a copy of the document titled Care Planning - Interdisciplinary Team. It included, but was not limited to, the following "...The Care Planning/Interdisciplinary Team is responsible for the periodic review and updating of care plans: When there has been a significant change in the resident's condition; When the desired outcome is not met; When the resident has been readmitted to the facility from a hospital stay; and At least Quarterly." 3.1-35(d)(2)(B)		be updated will be brought to clinical part of morning meeting-Monday thru Friday and will be updated by clinical team. -Audits will be completed Three times a week for one month, weekly for two months, semi-monthly for two months, then once monthly. Audits will be completed by MDS, SSD or their designee. All findings will be noted and brought to QAPI for review until 100% compliance has been achieved.	
F 0689 SS=D	483.25(d)(1)(2) Free of Accident			

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Bldg. 00	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 observation, record review, and interview, the facility failed to ensure care planned interventions for resident's who were identified as at risk for falls were implemented, for 2 of 3 residents reviewed for accidents. (Residents D and E) Findings include: 1. During an observation, on 2/22/21 at 11:50 a.m., both Resident D and Resident E's call light cords were tangled up and tied together in a large tangled knot where the call lights entered the wall. They were both several feet away from the residents beds. During an interview on 2/22/21 at 11:57 a.m., CNA (Certified Nurse Aide) 8 indicated housekeeping had tied the strings up when they were cleaning rooms, and it did not look like anyone had taken them back down. During an observation, on 2/24/21, between approximately 12:15 p.m. and 12:45 p.m., Resident D and Resident E's call light cords remained tangled in the same manner, and were unreachable by either resident. a. The clinical record for Resident D was reviewed on 2/23/21 at 9:18 a.m. Diagnoses	F 0689	F-689- Free of accidents/hazards, supervision/devices Residents D and E both have their care plan interventions implemented. Any resident identified as at risk for falls is at risk for this alleged deficient practice. An audit of 100% of the rooms were checked for call lights to be within reach for all residents. No other residents were found to be at risk as no other call lights were tied in a knot at the wall. Audit was completed by facility management team. Care Plans were reviewed for all residents identified as at risk for falls and interventions have been implemented as listed. -In-services on call lights and placement, resident safety/hazards, abuse, reporting/documentation, and using TELS will be completed for all facility staff by 3/26/2021. Inservice to be presented by Director of Nursing or her Designees. Staff will also be in-serviced on care-planned interventions for residents at risk	03/26/2021

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	included, but were not limited to, lack of coordination, abnormal posture, muscle weakness, and dementia. The care plan, dated 3/9/18, indicated the resident had the potential for falls, related to gait and balance. Interventions included, but were not limited to, be sure the resident's call light is within reach. b. The clinical record for Resident E was reviewed on 2/23/21 at 9:28 a.m. Diagnoses included, but were not limited to, dementia and muscle weakness. The care plan, dated 10/05/20, indicated the resident had the potential for falls related to confusion, gait imbalance problems, incontinence, poor communication and comprehension, psychoactive drug use, and unaware of safety needs. Interventions included, but were not limited to, be sure the resident's call light was within reach. The most recent Fall In-Service, provided on 2/24/21 at 2:15 p.m., by the DON, included but was not limited to, included, but was not limited to, "... call lights are to be within reach at all times..." 3.1-45(a)(1)		for falls and C.N.A. assignment sheets updated to reflect current interventions. -Audits will be completed by the DON or her Designees in the following timeframe: Daily for two months, three times a week for two months, then one time a week for two months. All audits will be brought to monthly QUAPI for review until 100% is achieved.	
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			

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	accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility 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.			

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	§483.70(i)(4) Medical records must be retained for- (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 interview and record review, the facility failed to ensure accurate medical records and documentation were maintained for 1 of 10 resident records reviewed. (Resident B) Findings include: Resident B's clinical record was requested on 2/22/21 at 10:15 a.m., Resident B's clinical record could not be located. The electronic medical record lacked documentation of the resident ever having been at the facility. The admission referral list, provided on 2/22/21 at 10:45 a.m., by the ED (Executive Director),	F 0842	F-842- Resident Records and Identifiable Information The facility does now ensure accurate medical records and documentation are maintained for all residents. All residents are at risk for this alleged deficient practice. An audit of the last 6 months of residents who left (AMA) Against Medical Advice was completed by Medical Records. All charts were checked for accuracy and that the facility policies and procedures were followed. No	03/26/2021

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	indicated the resident had been referred to them for admission on 11/18/20. During an interview, on 2/22/21 at 10:40 a.m., the ED indicated the facility had no clinical record for Resident B. She had been brought to the facility by EMS (Emergency Medical Services), and immediately decided she was not going to stay. She left shortly after arriving. They had not had time to start a medical record on her. During an interview, on 2/22/21 at 12:30 p.m., The DON (Director of Nursing) indicated Resident B had come to the facility and immediately left because she was unhappy with the room. The minute she had seen the room she had decided to leave. She could not recall receiving any paperwork on the resident. The resident would not sign an AMA (against medical advice) discharge form. Typically they would chart if the resident refused to sign but they didn't even have her admitted in their electronic medical record system. During an interview, on 2/22/21 at 12:45 p.m., LPN (Licensed Practical Nurse) 9 indicated she recalled the situation with Resident B. She had come in, as soon as she stepped through the doors she was unhappy. She was refusing to sign papers. If a resident refused to sign papers she would call the DON and let her know the situation, and there should have been a note made somewhere. " ... Definitely somewhere there should have been a note..." She would also have notified the doctor of the admission and that she was leaving. During an interview, on 2/23/21 at 10:13 a.m., the ED indicated normal process would be as soon as they received notice the resident was on		errors were noted. -To ensure errors do not happen again all nurses (RNs, LPNs, and QMAs), Admission staff, and Management staff that perform “Manager on Duty” during the weekends will be in-serviced on admissions, creating “quick ADT” for admitting residents, documenting admission notes, putting the chart together for new or emergent admits, AMAs, and refusal to sign AMA paperwork. In-service will be completed by 3/26/2021. -The Director of Nursing or her Designee will do an audit on any new admission and/or discharge. This audit will be done on all residents, who qualify, for the next 6 months. All information will be brought to monthly QAPI for review until 100% accuracy is achieved.	

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	their way to the facility from the discharging hospital or facility, an electronic medical record would be created. However the facility had received no notice the resident was on her way until she actually arrived at the facility, so a medical record had not been created for her. During an interview, on 2/23/21 at 12:38 p.m., LPN 7 indicated, she had been the admitting nurse for Resident B. The resident had immediately decided to leave and was upset. She tried to get her to stay but she would not. She tried to educate her and get her to sign an AMA form, but the resident refused, and left. She did not document it anywhere, she reported it to her DON and she "...took it from there...". No one instructed her to do any supplemental documentation. The only thing she did was report it to the DON. The Discharging a Resident without a Physician's Approval, last revised October 2012, provided on 2/23/21 at 9:00 a.m., included, but was not limited to, " ... 3. If the resident ... insists upon being discharged without the approval of the Attending Physician, the resident ... must sign a Release of Responsibility form. Should either party refuse to sign the release, such refusal must be documented in the resident's medical record and witnessed by two staff members." The Charting and Documentation policy, last revised 4/2018, provided on 2/25/21 at 1:00 p.m. by the ED, included, but was not limited to, "... All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's clinical records..." This Federal tag relates to complaint			

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	IN00342862. 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3)			
F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a safe and sanitary living environment for resident's. This deficient practice had the potential to affect all 61 resident's who currently resided at the facility. Findings include: 1. On 2/22/21 between approximately 9:30 a.m. and 10:30 a.m., the following observations were made: Room 125- The bath tub was leaking, black grime was built up in the bottom of tub. The grab handle was rusted. Room 13- The dry wall worn away, down to the metal on the corner by the sink, about 4 inches in height. The bathroom floor was sticky and had puddled yellow fluid. The toilet was covered in yellow stains. There was black grime built up around the baseboards. There was a yellow candy wrapper in the shower drain, and the drain was rusted. There was built up black grime around base of toilet. Room 17- The baseboard was peeling away from	F 0921	K921 Facility will ensue that all 61 residents will be ensured a safe and sanitary living environment. Room 125 the facility will fix leaking bathtub and remove black grime. Grab Bar will be free of rust in 125. Room 13 will have the drywall replaced by the sink Electrical outlet cover will be replaced. Bathroom floor will be cleaned. Toilet will be cleaned or replaced. Black grime around the base of the toilet will be cleaned. Drain will be free of rust. Black grime around the baseboards will be cleaned or baseboard will be replaced. Room 17 will have baseboard placed back on the wall. Will clean the bathroom door frame for rust. Dining Room in 1-2-3 Wallpaper will be cut out and painted. Room 47 black grime around the baseboards will be cleaned. Hole in the wall will be repaired.	03/26/2021

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	wall. Paint was peeling from the wall by the sink, and the bathroom door frame was rusted. The 1, 2, 3 Dining Room - had cracked paneling on the side wall at the entrance. The wall paper had been reglued, with hard, sharp edges pointing outward. Room 47- There was black grime built up around baseboards at entrance to room and there was a hole in wall approximately 2 inches in width by 3 inches in length on the right side of the entry way. Smoking Area- There were multiple, too many to count, discarded cigarette butts in smoking area, discarded in mulched garden area on patio. Trash, including a candy wrapper, a soft drink bottle, a disposable cup and lid, and two straws littered the walkway. There were three packs of cigarettes and a discarded black glove next to overflowing trashcan. 100 Hall Dining- The floor was coated in black grime, built up near edge trimming and around columns. During an observation on room 111 on 2/23/21 at 11:00 a.m., the dry wall in the right back corner of the room, over the closet, was crumbling away, exposing the beams of the ceiling and the wall. The wall was bubbling with water damage and lifting away from the structure from approximately 4 feet from the ground up to the ceiling. Several mall, 1 to 2 inch holes were gnawed in the drywall near the air conditioner and electrical outlets. Housekeeper 11 was present in the room and indicated at the time of observation the holes appeared to be from mice, and she had seen dead mice recently in the		Residents will not be permitted to smoke in front of the mulch in the Smoke Area. We are getting a bid for that to be turned into a concrete patio. Trash is being emptied as needed by Housekeeping staff. Hall 4 Dining room has had the floor replaced and new baseboards around the columns. Room 111 had wall and ceiling repaired and painted. Holes will be filled in and repaired. Room 101 drywall next to the AC/Heating unit was replaced. Light fixture in in bathroom will be replaced. Ceiling Tiles were replaced. Cable outlet cover will be replaced. Electrical outlet will be replaced, and wires will no longer be exposed. Room 107 will have electrical outlet replaced. Moist, black build up around window will be cleaned. Room 109 AC/Heating unit will have foam put around the edges so there are no sharp edges. Ceiling Tiles will be replaced. Brown and Pink grime in shower will be cleaned. Room 216 will have the light fixtured free of water. Ceiling tiles will be replaced. Room 214 Grime behind the toilet will be cleaned. Electrical outlet will be replaced. Hole and crack will be repaired. Outlet by the AC/Heating unit will be replaced. AC/Heating unit will have foam put around edges so there are no	

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	facility. She didn't think anyone was aware of the ceiling. It had been bubbling up but she just now noticed how bad it was. The resident was in the room in her chair approximately 4 feet away from the crumbling area of the ceiling. On 2/23/21 between approximately 11:20 a.m. and 12:30 p.m., the following observations were made: Room 101- The wall was crushed in at baseboard on the left side of heater. The bathroom light fixture had one lightbulb blown. The toilet was running. The ceiling tiles were stained and displaced. The cable outlet housing was cracked with sharp edges. The electrical outlet by bed housing detached and hanging by cords, with the face plate cracked and wires exposed. Room 107- The electrical outlet behind the bed was cracked, the internal fixtures within the housing were exposed. There was moist, black build up along the window. Room 109- The air conditioner housing had sharp metal edges exposed. The toilet was running. Multiple ceiling tiles were stained with water damage. The shower seat and floor were coated in brown and pink grime. Room 216- There was water staining inside the light fixture and water damage to the surrounding ceiling tiles. There was exposed ductwork in ceiling, where a ceiling tile was missing. Room 214- There was built up grime on the floor behind the toilet. An electrical outlet by bed A's TV was exposed, with no face. There was a crack running along the wall with a hole in the center, by the window, which measured approximately 4		sharp edges. Room 212 Cable outlet cover will be replaced. Call Light fixture will be replaced. Bathroom light will be repaired or replaced. Ceiling tiles will be replaced. Room 210 Electrical outlet will be replaced. AC/Heating unit will have foam put around edges so there are no sharp edges. Ceiling tiles will be replaced. Baseboard will be put back on the wall. Room 208 will have light cover replaced. Room 206 where its mudded, it will be painted. AC/Heating unit will have foam put around edges so there are no sharp edges. Room 204 thermostat cover will be repaired. Shower Drain cover will be replaced. Room 203 thermostat plate will be replaced. Power Strip will be replaced. TV will be removed from wall. Room 209 will have electrical outlet replaced. Room 211 will have shower curtain replaced. Bathroom Light will be replaced. Window will be repaired. Room 215 AC/Heating unit will have foam put around edges to so there are no sharp edges. Calcium and brown stains will be cleaned around the faucet and bathtub. Handrail outside of 216 will be repaired. Plug around the AC unit up in the	

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	inches in length by 2 inches in width. An electric outlet plug in by the air conditioner was cracked, coated in brown substance. The air conditioner trim was loose, with sharp metal edges exposed. Room 212- The cable housing had been pulled off wall, and was hanging by cord. The call light fixture was broken, with internal wires and housing exposed. The bathroom light was flickering. There was a ceiling tile missing with ductwork exposed. The toilet was running. Room 210- The electrical outlet behind bed was broken, with internal hardware exposed. The air conditioner cover was falling off, with exposed sharp metal edges. There were three stained ceiling tiles in the bathroom. There was a missing ceiling tile with ductwork exposed. The baseboard was peeling away from wall. Room 208- The light cover was loose, hanging over bed B. Room 206- The wall was mudded, but not painted. Two outlets by the air conditioner had no face plates. The air conditioner had sharp metal exposed edges. Room 204- The thermostat cover was displaced, hanging loose. The shower drain cover was off, with the drain pipe exposed. Room 203- The thermostat plate was cracked and had sharp edges. There was a power strip hanging from the TV plug, unsupported. Room 209- There was a cracked electrical outlet by the bed. Room 211- The toilet was running, the shower		Harbor will be replaced and AC unit will be cleaned. Window area will be free of sharp jagged edges. Wallpaper will be cut out and painted. Ceiling tile on the second floor right outside of elevator will be replaced. Room 102 ceiling tiles will be replaced. Floor tiles will be replaced. Electrical outlet will be replaced. Room 104 Electrical outlet cover will be replaced. Drywall around AC/Heating unit will be replaced. Thermostat knob will be replaced. AC/Heating unit will have foam put around edges so there are no sharp edges. Room 108 will have drywall repaired. Floor tile will be replaced/repaired. AC/Heating will have foam put around edges so there will be no sharp edges. Electrical outlet will be replaced. Faucet will be free of calcium buildup. Room 110 will have electrical outlet replaced and drywall will be repaired. Room 123 will have cable and electrical outlet cover replaced. Ceiling tiles will be replaced. Room 129 Drywall will be repaired by the heating unit. Ceiling tile will be replaced. Outlet cover will be replaced. Cable box outlet cover will be replaced. Area around the soap dispenser will be repaired. Facility has regular pest control	

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	curtain was ripped, with only approximately 1 foot of shower curtain hanging from rod. The bathroom light was blown. The bedroom window was open approximately 1 inch, cold air could be felt coming in, articles of clothing had been stuffed into the crack to cover it. CAN 13 was in the room and could not get the windows to close. Room 215- The air conditioner housing had sharp exposed metal edges. The cable housing was displaced, with internal hardware exposed. The light in the bathroom was blown. There was built up calcification to faucets and brown staining in the tub under faucet. The handrail by room 216 was missing its end cap, and had rough plastic edges exposed. The plug on the window air conditioning unit in the Harbor Dining room, was melted, with burn marks around the prongs. There was tissues, food wrappers, and food debris inside the unit. The outlet next to the unit was melted, with burn marks surrounding it. The window pane was loose, with sharp, jagged, metal edges exposed. The wallpaper was stained black and peeling away. On the second floor, directly in front of the elevator, a ceiling tile was missing with ductwork, attic beams, wiring, and insulation exposed. 2. During an observation on 02/23/21 between 11:35 and 12:47 p.m., the following observations were made: Room 102- the bathroom tiles were stained from water damage. The ceiling tiles were displaced. The air conditioner unit had sharp		and will have room sprayed for bugs and other pests. Night light will have cover replaced. Electrical outlet will be replaced. Room 53 the drywall will be painted where it was painted. Toilet lid will be replaced. Room 207 footboard will replace the trim or replace with new bed if trim cannot be repaired. Toilet Seat will be replaced. AC/Heating unit will have foam put around edges so there be no sharp edges. Electrical outlet will be replaced. Harbor nurses' station will have trim replaced. Register will be dust free and screwed to the wall. Handrail outside of room 108 will be replaced. Trim in Hall 4 Dining room will be replaced. Wall trim between Maintenance closet and Housekeeping closet will be replaced. Room 15 Rubber wall trim will be replaced. Brown discoloration will be cleaned. Ceiling tile will be replaced. Rubber piece under the handrail between rooms 17 and 18 will be replaced. Wallpaper outside dining room 1-2-3 will be cut out and painted. Handrail will also be tightened, and endcap will be replaced. Room 45 drywall by the bathroom door will be repaired. Ceiling outside of rooms 47 and 40 will be painted. Crack in ceiling will be repaired.	

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	edges. There were cracked floor tiles, and a cracked electrical outlet beside the base and television. Room 104 A cracked electrical cover with sharp edges, trim off walls, and the drywall around the heating and cooling unit was crumbling and peeling. The thermostat knob on the air conditioner had sharp edges. Room 108- the drywall tape and paint was peeling on the bathroom ceiling. Cracks in the floor tile beside the bed. The air conditioner had sharp edges. Bed B by the television had no protective plate over the electrical outlet. The bathroom had a calcium and grime buildup on the facets. Room 110- electrical outlet had no protective cover, and walls had several cracks in the drywall. Room 123- no protective cover on the cable box, water damage on ceiling, and no protective cover on electrical outlet. Room 129- the bottom right corner of the heating unit had drywall damage, water damage to bathroom ceiling tile, and a broken outlet plug. There was no protective cover over cable box,and plaster around the soap dispenser was gone. The toilet had continuous running water. Room 13- No protective electrical outlet cover. Room 16- a large cockroach was observed in the resident's bathroom on the ceiling beside light fixture. There was no protective cover over night light, and no protective cover over the electrical outlet.		Room 53 toilet lid will be repaired. Room 11 will have gauges in wall repaired. Ac/Heating unit will be placed in wall. Ceiling tiles will be replaced. Outlet will be replaced. Pest Control will spray for bugs and other pests. Thermostat cover will be replaced. Water Damage on floor in the bedroom will be clean/repaired. Room 15 drywall on outside wall be repaired. Ceiling tile will be replaced. Gouges on the wall will be repaired. Rubber trim in bathroom will be repaired/replaced. Room 17 will have rubber wall trim in bathroom placed back on the wall. Vent cover will be replaced or repaired. Room 18 Crack will be repaired. Ceiling tile will be replaced. Light cover in bathroom will be replaced. Room 42 will have gouge in the wall repaired. Room 43 water pooling up in the bathroom. Room 44 water will be drained. Room 46 wall by bathroom door will be repaired. Drywall above the window will be replaced. Light switch cover will be replaced. Ceiling tile outside of room 101 will be replaced. Room 103 will repair ceiling and replace ceiling tile. Room 105 floor tile will be repaired/replace. Trim will be repaired. Crack under AC/Heating unit will be repaired. Ceiling tiles	

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	Room 57- the drywall was observed to be chipped and peeling. Room 53- the drywall was patched and unfinished. The double electrical outlet cover was hanging off and trim missing. The bathroom toilet lid was sitting on the floor behind the toilet. Room 207 - the foot board on the resident's bed had no trim, was rough and press board exposed. The toilet seat was stained with a light brown substance. The air conditioner had sharp edges and the electrical outlet protective was cracked. On 2/22/21 between 9:25 a.m., and 10:02 a.m., the following observations were made: Harbor Unit - The rubber wall trim was missing, at the end of the hall, to the left side of the emergency exit door. The wall register, at the entrance into the nurse's station, was covered with dust. The top of the rust-colored wall register was pulling away from the wall, at the top, with loose screws or missing screws. Rubber trim was missing to the left side of the nurse's station door. On the 100 Hall - the corner of the handrail by Room 108 was missing. The rubber wall trim at the corner of the Main Dining Room was falling away from the wall. The rubber wall trim was missing between the Maintenance closet and the Housekeeping closet. The rubber wall trim to the left side of the Room 11's door and to the right of Room 12's door was		will be replaced. Bathroom door will be replaced. Room 112 wall around the soap dispenser will be repaired. Room 119 the ceiling will be repaired, Thermostat know will be replaced. Room 123 ceiling will be repaired. Outlet cover will be replaced. Room 129 Drywall will be repaired. Outlet will be repaired. Rubber trim will be replaced. Baseboard will also be repaired. Room 130 wall by the soap dispenser will be repaired. All residents have the chance of being affected. All staff will be In-Serviced before March 26th about the use of Power Strips in a resident room. All Staff will be In-Serviced on TELs Work Orders for all Environmental and Sanitary related issues by the Administrator/Designee. Facility Management will be assigned daily rounds for resident rooms and general areas to ensure that the facility a safe and sanitary environment. To ensure compliance, the Admin/designee will inspect 10 resident rooms and general areas daily for 4 weeks and 1 time weekly for 2 months, rotating the selection of rooms/areas. Results will be reviewed at the monthly	

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	missing. Room 15-the rubber wall trim was leaning outward to the right side of the sink. There was brown discoloration along the wall on the floor. The ceiling tile above the shower staff was bulging downward and was light brown in color. The corner piece of wall trim was missing under the handrail between Rooms 17 and 18. 2 rectangle shaped pieces of wallpaper, located by the CNA closet and across from the Medicine room prior to Entering the 1,2,3 Dining Room, there was peeling wallpaper at the top corners. The wallpaper was stiff from the glue and sharp to the touch. The handrail was loose in the same location and the corner end cap of the handrail was missing. The plasterboard wall to the left and right lower corners of room 45's bathroom door had crumbling plaster that was scattered on the floor. The ceiling above the hallway between Rooms 40 and 47 had an irregular shaped 2 foot by 1-foot brown discoloration. There was a 3-foot crack running across the center of the brown discoloration on the ceiling. The toilet tank lid was sitting on the floor in room 53's bathroom. There was water in the tank. There was brown discoloration along the wall at the left side of the room entrance. On 2/23/21 between 11:45 a.m. and 12:37 p.m., the following observations were made: Room 11-The plaster wall had scattered gouges on the right side of the room. The heating unit		QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised to ensure compliance.	

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	was pulled away from the wall. Two ceiling tiles had 1 crack each in the bathroom. The resident has seen roaches in her room. There was a cracked outlet in the corner of the room. The thermostat cover was missing. There was water damage on the floor of the bedroom. Room 15-The ceiling was cracking at the corner of the outside wall. There were scattered gouges in the plasterboard of the wall. The ceiling tile was bulging over the shower stall. The rubber trim under the sink was peeling away from the wall. Room 17-The rubber trim was peeling at the entrance to the bathroom. A small vent cover was laying on the floor. Room 18-The wall was cracked from the ceiling to the floor of the room. 1 ceiling tile was dislocated. The light in the bathroom had no cover over it. Room 40-The toilet tank was running water. Room 42-The wall behind the entry door had a gouge in the wallboard in the shape of the handle. The toilet tank was running. Room 43-The resident indicated the water pools on the floor drain in the bathroom, making her afraid of falling. Room 44-Water was observed, on the bathroom floor, by the drain for showers. Room 46-The lower part of the wall at the right side of the bathroom door was curving inward. The plaster on the wall above the window was crumbling away along the length of the window.			

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	155616	A. BUILDING 00 B. WING	02/24/2021

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	The light switch cover was broken off and wasn't protecting the switch from the water in the shower area of the bathroom. At the end of the 100 Hall-Irregularly shaped brown area on the ceiling tile outside of the Room 101 in the hall. Room 103-The ceiling at the right corner of the room was discolored and raised 2 feet from the corner out toward the window. Room 105-The floor tile was cracked in the left corner of the room with broken pieces. The trim had pulled away at the floor. There was a crack under the heating air unit with daylight shining through. Ceiling tile was missing above the sink with pipes visible. The 3rd ceiling tile from the sink had a brown discolored stripe across the tile. The cable box was misplaced. The door was peeling plastic internally damaged, with fascia lifting and sharp edges. Room 112-The wallboard paper was peeled away where the soap dispenser had been located. Room 119-The ceiling was bubbled and stained at the left corner of the room. The thermostat knob was missing. Room 123-The ceiling was bubbled at the right corner of the room 4 feet from the corner toward the window and 1 foot down the corner of the wall. An outlet at the right side of the entrance wall had no cover. Room 129-The bottom of the wall at the corner of the room had bubbling and discoloration to the heating unit. An outlet was broken on the top plug. The rubber trim was missing at the side of the bathroom door. Multiple holes were along			

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	the baseboard. Room 130 Peeling wall board paper under the soap dispenser. Toilet running water. During an interview on 2/22/21 at 10:28 a.m., The Maintenance director indicated he had started the position in January and was working on several projects. He didn't have a lot of tickets thought, if staff did not fill out tickets, he did not have a way to know what was needing fixed. He was still trying to figure out how to do his work week. During an interview on 2/22/21 at 10:35 a.m., the Maintenance Assistant indicated he was working on a lot of things mostly by himself. He could not focus on one thing because he gets called away to new problems. He had nothing to fix the hand rails, they didn't make them anymore. He hadn't had time to get up to the Harbor. He needed help to get all of the problems fixed. It was extremely hard to do the jobs that needed to be done, especially when he was on his own for 6 to 7 months. He had not gotten many work orders for the Harbor., maybe one in the last few weeks. He was aware of the water damage in Room 111. During an interview on 2/22/21 at approximately 10:45 a.m., the Executive Director indicated cigarette butts should be discarded in the ashtray which was available. Maintenance and housekeeping should be ensuring the smoking courtyard was free of trash. During an interview on 2/24/21 at 9:45 a.m., CNA 8 indicated the air conditioner and plug in had been burnt and melted for a little while, perhaps a couple of weeks. She didn't know why it hadn't been fixed.			

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	During an interview, on 2/24/21 between approximately 12:30 a.m. and 1:30 p.m., Resident G indicated she wished she could get many things in her room fixed. Her bed frame was rough and hurt her, the toilet seat and tub were stained. The resident was able to state her date of birth and name. During an interview, on 2/24/21 at 2:15 p.m., the Executive Director indicated, from approximately May to November, they had not had a consistent maintenance director. Things were not being completed and they were so busy focusing on COVID and infection control, it derailed facility maintenance. This Federal tag relates to Complaint IN00342862. 3.1-15(c)			
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00342862. Complaint IN00342862 - Substantiated. State Residential Finding related to the allegations is cited at R00148 and Federal/State deficiencies related to the allegations are cited at F0921 and F0842. Unrelated deficiencies are cited Survey date: February 22, 23 and 24, 2021 Facility number: 001145	R 0000		

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	Residential Census: 6 This State Residential Finding is cited in accordance with 410 IAC 16.2-5.			
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation and interview, the facility failed to ensure a safe and sanitary living environment for residents. This deficient practice had the potential to affect all 6 residents who currently resided at the facility. Findings Include: During the tour on 2/24/21 between 1:00 p.m. and 1:45 p.m., the following observations were made: Room 223- There was black, fuzzy spots, which	R 0148	R148 Facility will maintain a sanitary and safe living environment for residents. Residential room 223 will place new vent in bathroom and repair ceiling. Rust will be removed from the pipes. Bathtub will be free of brown and black grime. Drywall will be replaced. Floor tiles in bathroom will be replaced. Hole in the hallway will be repaired.	03/26/2021

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	appeared to be mold or mildew, covering the ceiling in the bathroom, behind the door, and in the shower. The pipes were rusted. The tub was coated in brown and black grime. The drywall was crumbling by the bathroom door. The floor tiles were cracked. There was a hole in the hallway, measuring approximately 2 feet wide, by 1 foot tall, which exposed the internal structure of the building, including wooden beams and pipes. Room 234- The outlets by the dresser and the closet were cracked. The Ceiling had water damage. Room 228- The outlet by the kitchenette had no faceplate. During an interview, on 2/24/21 at 2:15 p.m., the Executive Director indicated from approximately May to November they had not had a consistent maintenance director. Things were not being completed and they were so busy focusing on COVID and infection control, it derailed facility maintenance. This State tag relates to Complaint IN00342862.		Residential room 234 will have the outlets replaced. Ceiling Tiles will be replaced. Residential room 228 will have the outlet replaced. 6 residents up in the Residential area have the chance of being affected, Housekeeping and Maintenance staff will be In-Serviced on TELs Work Orders for all Environmental and Sanitary related issues in Residential areas by the Administrator/Designee. To ensure compliance, the Admin/designee will inspect occupied residential rooms and general areas daily for 4 weeks and 1 time weekly for 2 months, rotating the selection of rooms/areas. Results will be reviewed at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised to ensure compliance.	