STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155742	A. BUILDING 00 B. WING	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST ANDREWS HEALTH CAMPUS	1400 LAMMERS PIKE BATESVILLE, IN 47006

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: December 6, 7, 8, 12, 13, and 14, 2022 Facility number: 004671 Provider number: 155742 AIM number: 200538760 Census Bed Type: SNF/NF: 33 SNF: 22 Residential: 31 Total: 86 Census Payor Type: Medicare: 15 Medicaid: 19 Other: 21 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 21, 2022.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement 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 to respond to the allegation of noncompliance cited during the Annual Survey conducted December 6-14, 2022. Please accept this Plan of Correction as the provider's credible allegation of compliance as of January 6, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0641 SS=E Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to accurately complete MDS (Minimum Data Set) assessments related to anticoagulant medications for 5 of 18 residents reviewed for	F 0641	**F641 – Accuracy of Assessments** *"Facility failed to accurately complete MDS (Minimum Data*	01/06/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandon Back	Clinical Support	01/20/2023

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	accuracy of assessments. (Residents 48, 39, 36, 37, and 34) Findings include: 1. The clinical record for Resident 48 was reviewed on 12/13/22 at 3:16 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 11/25/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, inflammatory liver disease, hypertension, and diabetes. The resident had received an anticoagulant for seven of seven days during the review period. The physician's medication order for November, 2022, indicated the resident was prescribed Aspirin (antiplatelet) 81 mg (milligram) once a day. The November 2022 EMAR (Electronic Medication Administration Record) lacked documentation that the resident had received any anticoagulant during the review period. 2. The clinical record for Resident 39 was reviewed on 12/13/22 at 3:16 P.M. A Quarterly MDS assessment, dated 11/09/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, stroke, coronary artery disease, heart failure, hypertension, and diabetes. The resident had received an anticoagulant for seven of seven days during the review period. The physician's medication order for November, 2022, indicated the resident was prescribed Clopidogrel (antiplatelet) 75 mg once a day. The November 2022 EMAR lacked documentation that the resident had received an anticoagulant during the review period.		*Set) assessments related to anticoagulant medications for 5 of 18 residents reviewed for accuracy of assessments. (Residents 48, 39, 36, 37, and 34)."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Residents 48, 39, 36, 37, and 34 was affected by the alleged deficient practice with no adverse effects noted. - Residents had anticoagulant assessments completed and corrected as appropriate. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents have the potential to be affected by the alleged deficient practice. - MDS was educated on the completion of, assessing and monitoring residents for anticoagulant. - All inhouse residents currently receiving anticoagulants were audited on 12/14/2022 by the DHS/MDS/designee for anticoagulant therapy and current diagnosis to include that all residents on anticoagulants had MDS reviewed for completion of N0410. No residents qualified for	

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	During an interview on 12/13/22 at 3:22 P.M., the MDS Coordinator indicated to obtain resident information for the MDS assessments she would go through the the residents history and physicals, physician charting, progress notes, electronic mediation administration records, electronic treatment administration records, and events. For the resident medications she would not document Plavix as an anticoagulant but would document aspirin, warfarin, and Eliquis. 3. The clinical record for Resident 36 was reviewed on 12/13/22 at 10:27 A.M. A Scheduled 5-day MDS assessment, dated 11/28/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes, hypertension, and CVA (Cerebral Vascular Accident). The assessment indicated the resident received an anticoagulant medication on seven of the seven days of the review period. The physician's medication order for November, 2022, indicated the resident was prescribed Aspirin 81 mg once a day. The EMAR for November 2022 was provided by LPN 11 on 12/13/22 at 4:16 P.M. The record lacked documentation that the resident had received an anticoagulant during the review period. 4. The clinical record for Resident 37 was reviewed on 12/12/22 at 10:32 A.M. An Annual MDS assessment, dated 10/13/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension and Chronic Obstructive Pulmonary Disease. The resident received an anticoagulant for seven of the seven days during the review period. The physician's medication order for October, 2022, indicated the resident was prescribed		documentation change. Education provided: o RAI standard requirement for N0410: Medications Received r/t to anticoagulants **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - MDS/designee will ensure weekly MDS accuracy review of all anticoagulants through the clinical care meeting and assessment program monitoring tool to ensure that any residents with anticoagulant therapy has appropriate documentation with physician/resident/family/and outside service provider notified if applicable, and for proper monitoring weekly for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for 6 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** - DHS/MDS will be responsible for the comprehensive assessment program, monitoring compliance of the weekly procedure for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive	

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	Aspirin 81 mg once a day. The EMAR for October 2022 was provided by LPN 11 on 12/13/22 at 4:16 P.M. The record lacked documentation that the resident had received an anticoagulant during the review period. 5. The clinical record for Resident 34 was reviewed on 12/07/22 at 11:17 A.M. A Quarterly MDS assessment, dated 09/26/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension and muscle weakness. The resident received an anticoagulant for seven of the seven days during the review period. The physician's medication order for September, 2022, indicated the resident was prescribed Aspirin 81 mg once a day. The EMAR for September 2022 was provided by LPN 11 on 12/13/22 at 4:16 P.M. The record lacked documentation that the resident had received an anticoagulant during the review period. During an interview on 12/13/22 at 3:37 P.M., the MDS Coordinator indicated aspirin or plavix (Clopidogrel) was coded in error and should have not been coded as an anticoagulant on the MDS assessments. The RAI (Resident Assessment Instrument) medication coding guidelines were provided by the MDS Coordinator on 12/13/22 at 3:38 P.M. The guidelines indicated, "...Anticoagulant...Do not code antiplatelet medications such as aspirin..." 3.1-31(c)(13)		Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 01/06/2023	
F 0684 SS=E	483.25 Quality of Care			

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Bldg. 00	§ 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, interview, and record review, the facility failed to follow manufacturer's guidelines related to insulin pen usage (Resident 41); and follow physician's orders, ensure treatments were in place, and initiate monitoring of a wound (Residents 19, 28, and 48). for 4 of 17 residents reviewed for quality of care Findings include: 1. During a medication administration observation on 12/13/22 at 11:02 A.M., LPN (Licensed Practical Nurse) 10 prepared to administer Resident 41's routine and sliding scale insulin. LPN 10 removed the Novolog insulin pen from the medication cart and attached a capped needle to the pen. She held the pen sideways and indicated she was going to prime the pen. She dialed up 1 unit of insulin and pressed the button to expel the insulin. She then dialed up the ordered amount of insulin and administered the medication to the resident. During an interview on 12/13/22 at 11:07 A.M., LPN 10 indicated she should have cleansed the insulin pen with alcohol before she attached the needle, and she should have held the pen upright to prime it instead of sideways. The current Novolog package insert, with a revised date of 11/2019, was provided by the	F 0684	**F684 – Quality of Care** *"Facility failed to follow manufacturer's guidelines related to insulin pen usage (Resident 41); and follow physician's orders, ensure treatments were in place, and initiate monitoring of a wound (Residents 19, 28, and 48, respectively) for 4 of 17 residents reviewed for quality of care."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Residents 48 was affected by the alleged deficient practice. Event was immediately opened, and treatment initiated for skin event. - Resident 19, 28 was affected by the alleged deficient practice. Order for TED hose was immediately entered into EMR. - Resident 41 was affected by the alleged deficient practice. Clinician was immediately reeducated on manufacturer guidelines for insulin pen administration.	01/06/2023

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	Corporate Nurse Consultant on 12/13/22 at 4:13 P.M. The insert indicated, "...Before each injection...Pull off the pen cap...wipe the rubber stopper with an alcohol swab...To avoid injecting air and to ensure proper dosing...Turn the dose selector to select 2 units. Hold your insulin...Flex Pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the bottom all the way in...A drop of insulin should appear at the needle tip..." 2. On 12/06/22 at 1:02 P.M., Resident 19 was observed in her room laying on her bed. The resident was wearing blue jeans and green non-skid socks. The resident was not wearing TED hose (Thrombo-Embolic Deterrent stockings) The resident's legs were swollen, and she indicated her feet hurt. On 12/07/22 at 9:00 A.M., the resident was observed in her wheelchair in the hall near her room. The resident was wearing blue jeans and green non-skid socks. The resident was not wearing TED hose. On 12/08/22 at 9:53 A.M., the resident was observed in her room laying on her bed. The resident was wearing black slacks and green non-skid socks. The resident's legs were swollen, and she was not wearing TED hose. On 12/12/22 at 8:35 A.M., the resident was observed heading to her room in her wheelchair. The resident was not wearing TED hose. The resident's clinical record was reviewed on 12/12/22 at 9:30 A.M. An Annual MDS (Minimum Data Set) assessment, dated 08/24/22, indicated		**2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents have the potential to be affected by the alleged deficient practice. - All caregivers were reeducated on the skin assessment policy and procedure with concentration on, but not limited to, assessing and monitoring residents for skin impairment, verifying orders before initiating treatment/interventions, and documenting refusals when appropriate. - All inhouse residents audited on 12/14/2022 by the DHS/RN/designee for skin impairment, appropriate orders, and refusal documentation, as well as manufacturer administration guidelines for insulin pen administration. No residents qualified to be added to wound management or documentation changes. Education provided: o Weekly Skin Assessments o Documentation of assessment, evaluation, orders, interventions, and refusals if appropriate **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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	the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, atrial fibrillation, coronary artery disease, hypertension, and dementia. The resident required extensive staff assistance with dressing. The resident's December 2022 ETAR (Electronic Treatment Administration Record) was provided by the Corporate Nurse Consultant on 12/13/22 at 4:13 P.M. The current physician's orders included an opened ended treatment order, with a start date of 08/17/21, that indicated staff were to apply TED hose in the morning and remove them at night. The treatments were checked off as administered every day as ordered. The clinical record lacked documentation of the resident's refusal to wear TED hose prior to 12/12/22. During an interview on 12/12/22 at 11:00 A.M., CNA/QMA (Certified Nurse Aide/Qualified Medication Aide) 12 indicated the resident didn't like to wear the TED hose, and they just put non-skid socks on her. The aides were supposed to notify the nurse if a resident refused treatments. During an interview on 12/13/22 at 10:48 A.M., LPN 10 indicated the aides generally applied the hose, but the nurses check the residents to ensure the hose are on. If a resident refused, it would be documented in the ETAR. If a resident consistently refused a treatment, they would notify the MD. During an interview on 12/14/22 at 2:01 P.M., the Corporate Nurse Consultant indicated they could not provide a policy for following MD orders, it was just standard professional practice to follow		**practice does not recur?** - DHS/Nurse/designee will ensure weekly monitoring of documentation in the clinical care meeting to ensure that any residents with impaired skin has appropriate documentation and interventions, refusals are being documented when applicable, and orders/interventions are being verified before application weekly for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for 6 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** - DHS/Nurse/Designee will be responsible for monitoring compliance of the weekly summaries/audit's procedure for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 01/06/2023	

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	MD orders. 3. During an interview on 12/07/22 at 11:13 A.M., Resident 28's family member indicated the resident wore compression stockings. She thought staff applied the stockings when he would get up for the day. On 12/12/22 at 11:00 A.M., the resident was observed in the common area in his wheelchair. The resident was wearing blue compression stockings with zippers. CNA/QMA 12 indicated the resident's family member brought them. On 12/13/22 at 10:44 A.M., the resident was observed in the common area in his wheelchair. The resident was wearing blue compression stockings. The resident's clinical record was reviewed on 12/12/22 at 12:55 P.M. A Quarterly MDS assessment, dated 09/23/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, stroke, hypertension, aphasia, and hemiplegia/hemiparesis. The resident's current physician's orders were reviewed. There was no indication the resident had a physician's order for the compression stockings. During an interview on 12/13/22 at 10:48 A.M., LPN 10 indicated nurses could apply compression stockings as a nursing measure, but they would have to get physician's order for the treatment. During an interview on 12/13/22 at 3:37 P.M., the DON (Director of Nursing) indicated the resident should have a physician's order for the			

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	compression stockings. 4. During an observation on 12/06/22 at 2:27 P.M., Resident 48 was sitting in her room in a wheelchair. She had a white 4" (inch) x (by) 4" adhesive dressing to the right outer upper leg dated "11/30". During an observation and interview on 12/08/22 at 9:54 A.M., Resident 48 was sitting in her room in a wheelchair. The resident indicated she had a dressing on her right outer leg that had been there for a while. She wasn't sure what she had done. The resident pulled up her right pant leg and there were two white adhesive dressings covering the right outer leg. The dressing was dated 11/30. During an observation on 12/08/22 at 2:22 P.M., LPN 10 had gone into Resident 48's room and asked if she could observe her right leg. The resident pulled up her pant leg. The nurse donned gloves and removed the white adhesive dressings that were dated 11/30. The resident had 4 small scattered scabs. The clinical record for Resident 48 was reviewed on 12/08/22 at 10:08 A.M. A Quarterly MDS assessment, dated 08/25/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension and diabetes. The Point of Care Skin Problem form indicated the resident's skin was clear from 11/30/22 through 12/08/22. The residents clinical record lacked any documentation related to the areas to the right outer leg. During an interview on 12/08/22 at 2:13 P.M., LPN			

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	10 indicated the residents' skins were assessed daily. The Certified Nurse Aides would look at the residents' skin daily and report findings to the nurse. If the resident had any new skin concerns the nurse would initiate a new skin event in the clinical record. The event would include the type of skin concern, such as pressure, skin tears, and bruises, and include a measurement. She was unaware of Resident 48 having any skin issues at that time and looked in the resident's record. The resident's clinical record lacked any documented skin concerns. During an interview on 12/08/22 at 2:27 P.M., LPN 10 indicated the resident's clinical record should have had an event completed for the skin areas on the right leg. The current facility policy titled, "Guidelines for General Wound and Skin Care", with an approval date of 12/01/2021, was provided by the Corporate Nurse Consultant on 12/08/22 at 12:10 P.M. The policy indicated, "...to provide measures that will promote and maintain good skin integrity...Document the type of wound, location, stage [if applicable], length, width, depth in centimeters, base, drainage, periwound tissue, and treatment of the wound weekly using the wound/skin treatment flow sheet..." The current facility policy titled, "Guidelines for Weekly Skin Observation", with a review date of 03/16/22 was provided by the Corporate Nurse Consultant on 12/08/22 at 12:10 P.M. The policy indicated, "...to monitor the effectiveness of intervention for pressure reduction, identify areas of skin impairment in the early development stage and implement other preventative and/or treatment measures as indicated...Initiate applicable Wound Event if a new area of			

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	impairment is identified...In addition to the Weekly Observation by the licensed nurse, the nursing assistant shall observe the skin for areas of impairment with bathing and daily dressing and pericare and notify the nurse if an area is identified..." 3.1-37(a) 3.1-47(a)(1)			
F 0686 SS=D 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 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 interview, observation, and record review, the facility failed to prevent and correctly identify a pressure ulcer for 1 of 4 residents reviewed for pressure ulcers. (Resident 45) Findings include: During an interview and observation on 12/06/22 at 2:28 P.M., Resident 45 indicated she had a place on her right heel that she had been receiving treatments and had been to the doctor to have it looked at. She had a pressure relieving boot in	F 0686	**F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcer** *"Facility failed to prevent and correctly identify a pressure ulcer for 1 of 4 residents reviewed for pressure ulcers (Resident 45)."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Residents 45 was affected	01/06/2023

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	place. During an observation on 12/13/22 at 10:17 A.M., Resident 45 was sitting in her wheelchair in her room. The resident had a pressure relieving boot in place. She gave permission for the DON (Director of Nursing) to observe her right heel. The resident's heel was free from open areas and was clean, there was no redness observed. The clinical record for Resident 45 was reviewed on 12/08/22 at 10:43 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 11/16/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, multiple sclerosis, hypertension, diabetes, non-Alzheimer's dementia, anxiety, and depression. The resident had a diabetic ulcer. A Point of Care History for skin problems records indicated the resident's skin was clear from 08/01/22 through 08/31/22. A Facility Wound Management Detail Report, dated 08/15/22 at 1:30 P.M., indicated the resident had a diabetic ulcer to the right heel. The wound measured 1.5 cm (centimeters) x (by) 2.5 cm x 0.1 cm. There was a light amount of serosanguineous (pale red to pink, thin and watery) drainage. There was partial thickness loss (loss of the epidermis and into but not through the dermis). The wound edges were irregular and macerated/soft. A treatment was initiated. A Facility Wound Management Detail Report, dated 08/25/22 at 8:32 A.M., indicated the resident had a diabetic ulcer to the right heel. The wound measured 1.8 cm x 3.2 cm x 0.1 cm. There was a moderate amount of serosanguineous drainage. The wound was covered in 100% slough		by the alleged deficient practice with no adverse effects noted. - **Resident 45 documentation was corrected.** **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents have the potential to be affected by the alleged deficient practice. - All WCC RNs were reeducated on the wound management program policy and procedure with concentration on, but not limited to, assessing and monitoring residents for skin impairment, resident diagnosis, and wound care clinic notes and diagnosis. - All inhouse residents currently referred to wound care clinic were audited on 12/14/2022 by the DHS/WCC/designee for skin impairment and current diagnosis. No residents qualified to be added to wound management or have documentation changes. Education provided: o Wound Management Program Policy o Weekly Skin Assessments o Documentation of assessment, evaluation, and diagnosis o Communication to ancillary services including, but not limited to, wound care clinic	

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	(white/yellow, dead tissue). A Facility Wound Management Detain Report, dated 09/01/22 at 8:59 A.M., indicated the resident had a diabetic ulcer to the right heel. The wound measured 1.5 cm x 1.5 cm x 0.1 cm. There was a light amount of serosanguineous drainage. The wound had full thickness loss (through the dermis and down to the subcutaneous tissue, muscle), and was covered in 60% slough. There were treatments in place per the wound clinic. A Local Wound Clinic Note, dated 09/01/22, indicated the resident was seen for an initial visit. She presented with a wound to the right heel. The wound was a Stage 3 (full thickness tissue loss, subcutaneous fat may be visible, slough may be present but does not obscure the depth of tissue loss) pressure ulcer with ulceration of fat/eschar (black/dry tissue). There was a small amount of serosanguineous drainage. The wound measured 1.5 cm x 1.5 cm x 0.1 cm. A Facility Wound Management Detail Report, dated 10/06/22 at 10:50 A.M., indicated the resident had a diabetic ulcer to the right heel. The wound measured 1.2 cm x 1.4 cm x 0.1 cm. There was a moderate amount of serosanguineous drainage. The wound had full thickness loss and was covered in 30% slough. A Facility Wound Management Detail Report, dated 11/17/22 at 1:20 P.M., indicated the wound had healed. The clinical record lacked any documentation related to the right heel until it was an open ulcer. During an interview on 12/08/22 at 2:05 P.M., the local wound clinic indicated the resident had been		**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DHS/WCC Nurse/designee will ensure weekly monitoring diagnosis review of all wounds through the clinical care meeting and wound manager program monitoring tool to ensure that any residents with wounds has appropriate documentation and wound labeling in the wound management with physician/resident/family/and outside service provider notified if applicable, and for proper monitoring weekly for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for 6 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** - DHS/WCC Nurse/Designee will be responsible for the wound management program, monitoring compliance of the weekly procedure for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will	

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	seen for wound management for a wound to her right heel. Her initial visit was 09/01/22 and the first impression of the wound presented as a Stage 3 pressure ulcer. They had debrided the wound and it remained a Stage 3 following the debridement. After the debridement of the wound, it measured 1.5 cm x 1.5 cm x 0.1 cm. The wound had healed on 11/15/22. During an interview on 12/08/22 at 2:13 P.M., LPN (Licensed Practical Nurse) 10 indicated the residents' skins were assessed daily. The Certified Nurse Aides would look at the resident skin daily and report findings to the nurse. The nurses had an assessment order that would be documented on in the treatment record for a weekly skin assessment. If the resident had any new skin concerns the nurse would initiate a new skin event in the clinical record. The event would include the type of skin concern, such as pressure, skin tears, and bruises, and include a measurement. She was unaware of Resident 48 having any skin issues at that time, looked in the resident record, and the record had lacked any documented skin concerns. During an interview on 12/12/22 at 2:28 P.M., QMA/CNA (Qualified Medication Aide/Certified Nurse Aide) 13 indicated the resident didn't have any open wounds at that time but had a wound in the past that was on her right heel. It had started out as a small area. The CNAs would monitor the resident skins daily. If the resident had any new skin concerns of open areas, bruises, or any other concerns she would document it in the Point of Care History for skin and let the nurse know. During an interview on 12/12/22 at 2:45 P.M., LPN 11, the Wound Nurse, indicated the resident had gone out to the wound clinic for her right heel and		be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 01/06/2023	

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	the wound had since healed. The wound had started as a diabetic ulcer. The wound had needed some debridement. The resident skin was to be monitored by the CNAs with showers and they reported any new findings to the nurse. The nurse would also observer the residents' skin on their shower days. If the residents had any new skin concerns the CNAs could document in the Point of Care and the nurse would open a new skin event or wound management assessment? if it was an ulcer. When the resident had went out to the wound clinic and they classified the wound as a Stage 3 pressure ulcer, the facility did not classify it as a pressure ulcer because they believed it was a diabetic ulcer. The facility would not usually reclassify the wounds due to knowing the resident's history better. The resident had a history of diabetes. The staff should have noted reddened or boggy skin to the heel prior to it being open. There was no documentation related to the heel until the ulcer was open. The current facility policy titled, "Guidelines for General Wound and Skin Care", with an approval date of 12/01/2021, was provided by the Corporate Nurse Consultant on 12/08/22 at 12:10 P.M. The policy indicated, "...to provide measures that will promote and maintain good skin integrity...Document the type of wound, location, stage [if applicable], length, width, depth in centimeters, base, drainage, periwound tissue, and treatment of the wound weekly using the wound/skin treatment flow sheet..." The current facility policy titled, "Guidelines for Weekly Skin Observation", with a review date of 03/16/22 was provided by the Corporate Nurse Consultant on 12/08/22 at 12:10 P.M. The policy indicated, "...to monitor the effectiveness of intervention for pressure reduction, identify areas			

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	of skin impairment in the early development stage and implement other preventative and/or treatment measures as indicated...Initiate applicable Wound Event if a new area of impairment is identified...In addition to the Weekly Observation by the licensed nurse, the nursing assistant shall observe the skin for areas of impairment with bathing and daily dressing and pericare and notify the nurse if an area is identified..." The current "Pressure/Stasis/Arterial/Diabetic Wound Guidelines" policy, with a revised date of 12/01/21, was provided by the Corporate Nurse Consultant on 12/12/22 at 3:59 P.M. The policy indicated, "PURPOSE...To provide weekly documentation of wound measurements and condition..." The current facility policy titled, "Guidelines for Pressure Prevention", with a revision date of 12/01/21, was provided by the Corporate Nurse Consultant on 12/12/22 at 3:59 P.M. The policy indicated, "...To maintain good skin integrity and avoid development of pressure ulcers... 3.1-40(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of			

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	motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to ensure the physician's orders were in place for 1 of 2 residents reviewed for the use of splint/brace devices. (Resident 36) Findings include: During an interview on 12/07/22 at 9:40 A.M., Resident 36 indicated he had a splint device that he wore for his right arm when he was out of bed. On 12/12/22 at 10:21 A.M., Resident 36 was observed in his wheelchair in the library watching television. A splint/brace device was in place on his right arm. During an interview on 12/13/22 at 11:42 A.M., OTR (Occupational Therapist Registered) 14 indicated the resident used a palm protector and dynamic elbow splint. The directions were to apply them in the morning, take them off at night. The therapy department used a communication sheet with instructions for use. Nursing staff would generate an order for use from the therapy instructions. The Occupational Therapy Discharge Summary, dated 11/17/22, was provided by the ADON (Assistant Director of Nursing) on 12/13/22 at 4:13 P.M. The summary indicated, "...Fitted patient	F 0688	**F688 – Increase/Prevent/Decrease in Mobility** *"Facility failed to ensure the physician's orders were in place for 1 of 2 residents reviewed for the use of splint/brace devices. (Resident 36)."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Resident 28 was affected by the alleged deficient practice. When resident refuses splint, documentation is immediately entered into EMR. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents have the potential to be affected by the alleged deficient practice. - All residents with brace/splint intervention were assessed for appropriate orders	01/06/2023

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	with dynamic right elbow splint...also continue with right palm protector...caregivers trained in application and wearing schedule..." The resident's clinical record was reviewed on 12/13/22 at 10:27 A.M. A Scheduled 5-day MDS (Minimum Data Set) assessment, dated 11/28/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes, hypertension, and CVA (Cerebral Vascular Accident). The resident required extensive staff assistance for most ADLs (Activities of Daily Living). There was a functional limitation in range of motion for one upper extremity and both lower extremities. The resident's current medication and treatment orders lacked a physician's order for use of the palm splint or brace device. During an interview on 12/13/22 at 10:48 A.M., LPN (Licensed Practical Nurse) 10 indicated a resident should have a physician's order for a splint or brace device. The aides or nurses would put the devices in place. If a resident was wearing a brace or splint device, the nurse would check to make sure it wasn't too tight, and they would monitor the skin under the device every shift. During an interview on 12/13/22 at 3:38 P.M. the Director of Nursing indicated a resident should have a physician's order for a brace or splint device. A procedural document, titled "Tasks Steps", with a reviewed on date of 09/30/2016, was provided by the Corporate Nurse Consultant on 12/14/22 at 3:00 P.M. The document indicated, "...Splint/Orthotics...If Therapy is discharging resident from POC and device is to be continued		and documentation. - Nurses/caregivers were reeducated on assessments and implementation of physician ordered interventions, including but not limited to, the application of ROM devices such as splints. Additional education was provider for documentation practices and the necessity to document refusals of care. Education provided: o Splint application o Standard documentation practices r/t refusals of care. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DHS/Nurse/designee will ensure weekly monitoring to ensure that any residents with ROM splint administration is being applied appropriately and or documented as refused and weekly for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for 6 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** - DHS/Designee will be responsible for monitoring compliance of the weekly process for 6 months. The results of these	

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	beyond POC, PD communicates to nursing in CCM meeting. Nursing writes order for device following therapy D/C..." 3.1-42(a)(2)		audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 01/06/2023	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			

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	Based on observation, record review, and interview, the facility failed to ensure a resident was free from unnecessary medications related to following a physician's order for hold parameters for a cardiovascular medication for 1 of 6 residents reviewed for unnecessary medications. (Resident 34) Findings include: On 12/07/22 at 9:06 A.M., Resident 34 was observed sitting in a wheelchair in a common area across from the nurses' station. He was awake and alert with no signs or symptoms of acute distress. The clinical record was reviewed on 12/07/22 at 11:17 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 09/26/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension and muscle weakness. The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) was reviewed on 12/08/22 at 3:23 PM. and included the following physician's order: - Cozaar (losartan) tablet 50 mg (milligrams) once a day, for hypertension, hold for blood pressure less than 110/60 or heart rate below 60, with a start date of 05/31/2022 and a discontinued date of 10/25/2022. The EMAR/ETAR for the Cozaar medication from 05/31/22 to 10/25/22, was provided by the ADON (Assistant Director of Nursing) on 12/13/22 at 4:13 P.M. The record lacked documentation that the heart rate was monitored prior to the administration of the daily medication for the	F 0757	**F757 – Drug Regimen is Free from Unnecessary Drugs** *"Facility failed to ensure a resident was free from unnecessary medications related to following a physician's order for hold parameters for a cardiovascular medication for 1 of 6 residents reviewed for unnecessary medications. (Resident 34)."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Residents 34 was affected by the alleged deficient practice. Resident assessment was completed, and no adverse effects noted. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents have the potential to be affected by the alleged deficient practice. - All nurses were reeducated on medication administration policy and procedure with concentration on, but not limited to, assessing residents for medication appropriateness, and adhering to medication parameters ordered by the physician. - All inhouse residents currently receiving medications	01/06/2023

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	duration the resident received the medication. The Care Plan for "High Risk Medications" with the potential for cardiovascular distress related to a diagnosis of hypertension was provided by the ADON on 12/13/22 at 4:13 P.M. The interventions included, but were not limited to, "...Obtain vital signs as ordered and needed..." During an interview on 12/13/22 at 12:32 P.M., LPN 10 indicated when a resident had a medication with hold parameters for cardiac medications there should be vital signs documented on the MAR/ETAR with the medication order. They would put the blood pressure and/or the heart rate values in the EMAR, then either give the medication or hold it based on the values of the required vital signs. There was a box on the EMAR/ETAR to add a note for the reason the medication was held. The current Guidelines for Medication Orders policy, with a reviewed date of 12/01/21, was provided by the Corporate Nurse Consultant on 12/14/22 at 9:50 A.M. The policy indicated, "...When recording medication orders specify...type, route, dosage, frequency, strength..." 3.1-48(a)(6)		with ordered parameters were audited on 12/14/2022 by the DHS/designee. No residents identified for medication parameter violations. Education provided: o Medication Administration Guidelines o Medication parameters **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DHS/designee will ensure weekly monitoring for medication parameter adherence for residents with ordered medication parameters including, but not limited to, blood pressure. Proper monitoring will occur weekly for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for 6 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** - DHS/Designee will be responsible for monitoring compliance of the weekly process for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The	

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			facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 01/06/2023	
F 9999 Bldg. 00		F 9999	**F9999– Personnel Authority** *"Facility failed to complete criminal background checks on minors hired to work in the facility. (Employees 4, 6, 7, and 8)* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Employee 4 had a hired date of 11/15/22, Employee 6 had a hired date of 04/06/22, Employee 7 had a hired date of 03/16/22, and employee 8 had a hired date of 10/12/22. - Employees were contacted to obtain background check from ISPD and bring into place of employment as per state guidelines. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All employees under the age	01/06/2023
	410 IAC 16.2-3.1-14 Personnel Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 16-28-5-1; IC 16-28-13-3 Sec. 14. (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to complete criminal background checks on minors hired to work in the facility. (Employees 4, 6, 7, and 8) Findings include: The following employees were hired and lacked a criminal background check in their employee files: - Employee 4 had a hired date of 11/15/22, - Employee 6 had a hired date of 04/06/22, - Employee 7 had a hired date of 03/16/22, and - Employee 8 had a hired date of 10/12/22. During an interview on 12/13/22 at 9:55 A.M., the			

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	Business Office Manager indicated a background check was initiated for all employees. Employees under the age of 18 should have had a State Police background check completed with fingerprints. The current facility policy titled "Pre-Employment Screening - Minors" with an approval date of 06/21/19, was provided by the Corporate Nurse Consultant on 12/13/22 at 4:13 P.M. The policy indicated "...A background check, which varies by position, will be conducted on employment candidates of this company. This includes full-time, part-time, and PRN (as needed) employees and minors under the age of 18 per applicable state specific guidelines..."		of 18 (minors) have the potential to be affected by the alleged deficient practice. - AP Payroll/ED were reeducated on hiring process with concentration on, but not limited to, background checks. Education provided: o Pre-Employment Screening - Minors **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - ED/AP Payroll/Designee will ensure monitoring of all minor new hires weekly for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for 6 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** - Designee will be responsible for monitoring compliance of the weekly process for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for	

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	155742	A. BUILDING 00 B. WING	12/14/2022

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			sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 01/06/2023	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: December 6, 7, 8, 12, 13, and 14, 2022 Facility number: 004671 Residential Census: 31 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on December 21, 2022.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement 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 to respond to the allegation of noncompliance cited during the Annual Survey conducted December 6-14, 2022. Please accept this Plan of Correction as the provider's credible allegation of compliance as of January 6, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following:			

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	(1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed to ensure residents that self-administered medications were assessed for self-medication administration for 2 of 5 residents reviewed for medication administration. (Residents 10 and 11) Findings include: 1. On 12/13/22 at 11:14 A.M., QMA (Qualified Medication Aide) 15 prepared Resident 10's medications. The QMA placed a calcium carbonate-vitamin D3 tablet, a multivitamin tablet, and two 100 mg (milligram) gabapentin (a medication used for pain) tablets in a medication cup. The QMA entered the room, assessed the resident's blood sugar, and left the cup of medications on a table in the room. The QMA indicated the resident didn't like them to give her the pills, and the resident was allowed to self-administer medications. She knew the resident took her insulin and eye drops with her when she left the facility. The QMA indicated she was told if a resident was "with it" she could leave the medications in the room. She would check on the resident when they delivered lunch to see if she took her pills. The resident's clinical record was reviewed on 12/13/22 at 11:30 A.M. The diagnoses included,	R 0216	**R216 – Evaluation - Noncompliance** *"Facility failed to ensure residents that self-administered medications were assessed for self-medication administration for 2 of 5 residents reviewed for medication administration. (Residents 10 and 11)."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Residents 10 and 11 was affected by the alleged deficient practice. Resident assessment was completed, and no adverse effects noted. - Clinician entered room and administered medications. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents have the potential to be affected by the alleged deficient practice.	01/06/2023

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	but were not limited to, hypertension, diabetes, anemia, dizziness, and giddiness. A Self Administration of Medication Observation, dated 03/31/22, indicated the resident wanted to self-administer insulin and eye drops. The evaluation indicated it was not appropriate for the resident to self-administer any medications. 2. On 12/13/22 at 11:21 A.M., QMA 15 prepared Resident 11's medications. The QMA placed two 1000 mcg (microgram) Vitamin B-12 tablets, two 325 mg Tylenol tablets, a multivitamin tablet, and a Gas-X Extra Strength 125 mg capsule into a medication cup. She entered the resident's room and poured the pills into a little blue bowl on the resident's table so the resident could see them. She documented that she gave the resident her pills in a notebook that was sitting near the table. The QMA indicated the resident got really confused as to whether she received her medication, so they wrote it down in the notebook so the resident would know she got her pills. The QMA left the medications in the bowl and left the resident's room. Resident 11's clinical record was reviewed on 12/13/22 at 11:45 A.M. The diagnoses included, but were not limited to, vascular dementia, diabetes, and hypertension. The clinical record lacked documentation the resident was assessed for self-administration of medications. During an interview on 12/13/22 at 11:38 A.M., the DON (Director of Nursing) indicated residents should be assessed and approved to self-administer medications. The current facility policy, titled "Guidelines for Self-Administration of Medications", with a		- Nurses/QMA were reeducated on medication administration with concentration on, but not limited to, residents' appropriateness for self-administration of medications. Education provided: o Guidelines for Self-Administration of Medications **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DHS/designee will ensure weekly monitoring during medication administration times to ensure that any residents appropriate for self-administration of medication is ordered and documented weekly for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for 6 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** DHS/Designee will be responsible for monitoring compliance of the weekly process for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through	

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	reviewed on date of 12/01/21, was provided by LPN (Licensed Practical Nurse) 11 on 12/13/22 at 3:55 P.M. The policy indicated, "...Residents requesting to self-medicate...shall be assessed...results of the assessment will be presented to the physician for evaluation and an order for self-medication...the Assessment will be reviewed quarterly, and PRN with change of condition..."		the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 01/06/2023	