STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155607	A. BUILDING 00 B. WING	04/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHEL MANOR	6015 KRATZVILLE RD EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00406154, IN00404282, IN00404286, and IN00401379. Complaint IN00406154 - No deficiencies related to allegations are cited. Complaint IN00404282 - Federal/State deficiencies related to the allegations are cited at F688. Complaint IN00404286 - Federal/State deficiencies related to the allegations are cited at F688. Complaint IN00401379 - Federal/State deficiencies related to the allegations are cited at F688. Survey dates: April 17, 18, 19, 20, and 21, 2023 Facility number: 000436 Provider number: 155607 AIM number: 100275120 Census Bed Type: SNF/NF: 55 SNF: 6 Total: 61 Census Payor Type: Medicare: 4 Medicaid: 35 Other: 22 Total: 61 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective May 22, 2023 to the annual licensure survey conducted April 17, 2023 through April 21, 2023. **We respectfully request a paper compliance/desk review.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Morgan Branning	Administrator	05/15/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed May 1, 2023.			
F 0688 SS=E 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 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 residents who required restorative nursing services received services for 7 of 8 residents reviewed. (Resident B, Resident C, Resident E, Resident F, Resident G, Resident H, Resident J) Findings include: 1. On 4/18/23 at 8:21 A.M., Resident B was observed sitting in a chair, rocking with her eyes closed, and the TV turned on. On 4/18/23 at 12:44 P.M., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, age-related osteoporosis	F 0688	**Is it the practice of Bethel Manor to ensure residents who enter without limited range of motion do not experience reduction in range of motion, unless clinical condition states that a reduction is unavoidable.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** An identification list was not provided for residents listed in F688. ***Other residents that have the***	05/22/2023

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	and congenital (present form birth) blindness. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 1/17/23, indicated Resident B was moderately cognitively impaired and that AROM (active range of motion) restorative therapy was provided 4 of 7 days and walking restorative therapy was provided 2 of 7 days within the seven day look back period. Resident B required extensive assist of 1 staff for bed mobility, transfers, and toileting. Care plans included, but were not limited to: Resident requires RNP (Restorative Nursing Program) for ROM (Range of Motion), revised 3/8/22. The interventions included, but were not limited to, document participation in program daily, monitor progress, resident will perform active range of motion to bilateral lower extremities and ankles seated for 15 repetitions 6 to 7 times per week. Resident requires RNP for walking, revised 3/8/22. The interventions included, but were not limited to, document participation in program daily, monitor progress, and resident will walk with four wheeled walker, gait belt, and contact guard assist 150 feet in the hallway 6 to 7 times per week. A Physical Therapy discharge summary, dated 9/22/22, indicated the resident required RNP to maintain the current level of function. A Nursing Rehab task from 3/1/23 to 4/19/23 indicated that Resident B did not receive restorative nursing services with AROM on the following dates: 3/2/23 3/3/23 3/6/23		***potential to be affected have been identified by:*** All residents have the potential to be affected. Due to lack of identifiers given by the state, we were unable to identify if the residents involved had a decline. All resident care plans were audited for restorative programming. Residents care planned for restorative were reviewed and revised by the therapy manager and MDS nurse. A revised restorative list and schedule was provided to the restorative aide. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** A Restorative Aide was designated for the role. All residents' care plans were audited and reviewed for restorative programs. The Therapy manager and MDS Coordinator reviewed and revised the number of residents receiving restorative program. All CNA's and QMA's have been educated and in serviced on restorative programming. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure residents who are care planned for	

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	3/8/23 3/10/23 through 3/26/23 3/29/23 through 3/31/23 4/3/23 4/6/23 4/8/23 through 4/14/23 4/16/23 through 4/19/23 A Nursing Rehab task from 3/1/23 to 4/19/23 indicated that Resident B did not receive restorative nursing services with walking on the following dates: 3/2/23 3/3/23 3/6/23 3/8/23 3/10/23 through 3/26/23 3/29/23 through 3/31/23 4/3/23 4/6/23 4/8/23 through 4/14/23 4/16/23 through 4/19/23 2. On 4/18/23 at 10:14 A.M., Resident C indicated she should be getting restorative services, and the staff did their best, but they were short staffed. On 4/19/23 at 2:08 P.M., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, right knee unilateral primary osteoarthritis, and left knee unilateral primary osteoarthritis. The most recent Annual MDS assessment, dated 2/21/23, indicated Resident C was cognitively intact and required the supervision of 1 staff for bed mobility, transfers, and toileting. It also indicated that AROM (active range of motion) restorative therapy was provided 0 of 7 days and		restorative are receiving restorative nursing. This tool will be completed by the Administrator or designee, weekly for four weeks, then monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	walking restorative therapy was provided 0 of 7 days within the seven day look back period. Care plans included, but were not limited to: Resident requires RNP of ROM, revised 3/30/21. The interventions included, but were not limited to, resident will perform AROM (Active Range of Motion) to BLE (bilateral lower extremities) seated or lying down for 10 repetitions and BUE (bilateral upper extremities) strengthen tasks with 1-3 pound weights for 10 repetitions 6-7 times per week, dated 12/27/22. Resident requires RNP for walking, revised 3/30/21. The interventions included, but were not limited to, resident will walk 20-40 feet with four wheeled walker, gait belt, and stand by assistance or contact guard assistance with wheelchair following behind 6-7 times per week. A Nursing Rehab task from 3/1/23 to 4/19/23 indicated that Resident B did not receive restorative nursing services with AROM on the following dates: 3/3/23 3/6/23 3/8/23 through 3/17/23 3/20/23 through 3/23/23 3/25/23 3/27/23 3/29/23 through 3/31/23 4/1/23 4/3/23 4/4/23 4/6/23 through 4/9/23 4/13/23 4/14/23 4/16/23 4/17/23 4/19/23			

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	A Nursing Rehab task from 3/1/23 to 4/19/23 indicated that Resident B did not receive restorative nursing services with walking on the following dates: 3/1/23 through 3/6/23 3/8/23 through 3/25/23 3/27/23 through 3/31/23 4/1/23 through 4/10/23 4/12/23 through 4/19/23 During an interview on 4/21/23 at 9:00 A.M., Resident C indicated that she felt weaker when she transferred from the bed to her wheelchair and when transferring to go to the bathroom. During an interview on 4/21/23 at 11:25 A.M., CNA 60 indicated after the last restorative aide left, the CNAs were supposed to do restorative care with the residents on their list. At that time, she indicated that they try to do some restorative services during care if they can. She further indicated recently she was going to walk Resident B but then got pulled somewhere else and never got back to do it. 3. On 4/17/23 at 10:02 A.M., Resident H was observed in wheel chair. On 4/19/23 at 11:40 A.M., Resident H was observed in a wheel chair sitting in the hall way with fellow residents. On 4/18/23 at 2:41 P.M., Resident H's clinical record was reviewed. The diagnosis included, but was not limited to, unspecified dementia. The most recent Quarterly MDS assessment, dated 3/23/23, indicated Resident H's cognition was severely impaired. Resident H required extensive assist for transfer and dressing.			

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	The Care Plans included, but were not limited to: Resident requires RNP for ROM, revised 11/2/22. The interventions included, but were not limited to, AAROM (Active Assisted Range of Motion) to BUE seated for 15 repetitions 6-7 times per week. A Nursing Rehab task from 4/1/23 through 4/16/23 indicated Resident H did not receive the restorative nursing services with AAROM to BUE on the following dates: 4/1/23 through 4/3/23 4/5/23 through 4/8/23 4/10/23 through 4/16/23 4. On 4/17/23 at 10:05 A.M., Resident J was lying in bed with the head of bed slightly elevated with her left leg on the pillow. On 4/18/23 at 12:57 P.M., Resident J's clinical record was reviewed. The diagnosis included, but was not limited to, unspecified dementia. The most recently Quarterly MDS assessment, dated 1/23/23, indicated that Resident J was severely cognitively impaired. Resident J needed extensive assistance of 1 with transfers. The Care Plans included, but were not limited to: Resident requires RNP of ROM, revised 3/24/23. The interventions included, but were not limited to, resident will perform AAROM/AROM to BUE/BLE being mindful of posterior hip precautions for 15 repetitions 6 to 7 times per week. A Nursing Rehab task from 4/1/23 through 4/18/23 indicated Resident J did not receive the			

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	restorative nursing services with AAROM/AROM to BUE/BLE on the following dates: 4/1/23 through 4/3/23 4/5/23 through 4/8/23 4/10/23 through 4/18/235. On 4/17/23 at 10:00 A.M., Resident E was observed dressed and sitting up in a wheelchair. On 4/21/23 at at 9:47 A.M., Resident E's clinical records were reviewed. The diagnoses included, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, muscle weakness, and difficulty in walking, The Quarterly MDS assessment, dated 4/18/23, indicated the resident was cognitively intact and required extensive assistance of one for bed mobility, extensive assist of two for transfers, supervision of one assist for eating, and was totally dependent for toileting and bathing. Current physician orders included, but were not limited to: - AAROM to left upper extremity/active range of motion to right upper extremity for 15 repetitions 6-7 times per week, ordered on 3/21/23. - Transfers from bed to wheelchair (stand pivot transfer) with device 2-3 repetitions 6-7 times per week, ordered on 3/21/23. A Nursing Rehab task documentation from 3/22/23 to 4/18/23 indicated the resident did not receive restorative nursing services for active assisted range of motion to left upper extremity/active range of motion to right upper extremity for 15 repetitions 6-7 times per week on:			

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	3/23/34 through 4/4/23 4/6/23 4/7/23 4/9/23 through 4/18/23 A Nursing Rehab task documentation from 3/22/23 to 4/18/23 indicated the resident did not receive restorative nursing services for transfers from bed to wheelchair (stand pivot transfer) with device 2-3 repetitions 6-7 times per week on: 3/23/23 through 4/4/23 4/6/23 4/7/23 4/9/23 through 4/18/236. On 4/19/23 at 9:20 A.M., Resident G was observed sitting in her wheelchair in her room eating breakfast. On 4/18/23 at 1:43 P.M., Resident G's clinical record was reviewed. The diagnoses included, but were not limited to, heart failure, osteoporosis, and chronic pain. The most recent Quarterly MDS assessment, dated 3/7/23, indicated Resident G was cognitively intact. Resident G required supervision of one with bed mobility, transfers, and toilet use. Resident G required set up help only with eating and bathing. A Care Plan, dated 6/2/22, indicated Resident G requires RNP (Restorative Nursing Program) of ROM (range of motion). The interventions, dated 6/2/22, included, but were not limited to, document participation in program daily, monitor progress, resident will perform AAROM/AROM to BUE seated for 15 repetitions 6-7 times per week. A Care Plan, dated 6/2/22, indicated Resident G requires RNP of walking. The interventions, dated			

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	6/2/22, included, but were not limited to, document participation in program daily, monitor progress, resident will walk 150-200 feet with front-wheeled walker, gait belt, and stand by assist/contact guard assist to eat in dining room or participate in activities 6-7 times per week. Physical therapy evaluation and plan of treatment, dated 9/15/22, indicated will discharge with RNP and resident may be up ad lib [as desired] in her room." Nursing Progress Notes included the following information: On 3/7/23 at 8:17 P.M., Resident is in RNP for AAROM/AROM BUE/BLE seated for 15 repetitions 6-7 times a week. Resident has not participated in task in look back period. Resident is also in RNP for walk 150-200 feet four wheeled walker, gait belt, and stand by assist/contact guard assist to eat in dining room or participate in activities 6-7 times a week. Resident has not participated in task in look back period. Quarterly evaluation of RNP completed on this date. Resident has not participated in either RNP task in 7 day look back period. Will continue RNP and tasks/goals involved and will reevaluate at next assessment period or sooner if need arises. On 4/19/23 at 1:20 P.M., the DON (Director of Nursing) provided a nursing rehab task documentation for March and April, 2023 which indicated Resident G received AAROM/AROM on 3/21/23 and 3/27/23. Resident G did not walk 150-200 feet in March or April.7. On 4/19/23 at 10:09 A.M., Resident F was observed sitting in her wheelchair in the lobby area of the unit. On 4/19/23 at 8:18 A.M., Resident F's clinical			

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	record was reviewed. The diagnoses included, but were not limited to, Alzheimer's dementia, muscle weakness, and difficulty in walking. The Quarterly MDS assessment, dated 3/14/23, indicated Resident F's required extensive assistance from staff for eating, bed mobility, and transfers. The Care Plans included but were not limited to: Resident requires RNP of ROM, dated 5/20/22. The interventions included, but were not limited to, document participation in program daily, monitor progress, resident will perform AROM/AAROM to BUE/BLE seated or lying down for 15 repetitions 6-7 times per week. A Nursing Rehab documentation report from 4/1/23 through 4/19/23 indicated Resident F did not receive RNP with AROM on the following dates: 4/1/23 through 4/3/23 4/5/23 through 4/8/23 4/10/23 through 4/13/23 4/15/23 through 4/19/23 During an interview on 4/19/23 at 11:49 A.M., CNA 7 indicated she thought there was a restorative aide that comes once a week or maybe it was therapy she did not know the answers. During an interview on 4/20/23 at 2:03 P.M., LPN 21 indicated there was not a restorative aide and she was not sure who was in charge of doing restorative services, probably CNA's. During an interview on 4/20/23 at 2:09 P.M., the MDS Coordinator indicated they had not had a restorative aide for at least 6-8 months. The CNA's			

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	should have known who the residents were that needed restorative services from the updated list. She indicated the services should be documented in tasks if completed or if the resident refused. During an interview on 4/21/23 at 8:24 A.M., RN 3 indicated that it was the responsibility of the CNA assigned to the unit to perform restorative therapy care for residents on the restorative care list, and that the schedule used by the CNA, to know who is on the care list, was updated immediately after a new order was placed for restorative care. On 4/21/23 at 3:05 P.M., a current "Restorative Nursing Services" policy, revised July 2017, was provided by the Administrator and indicated "Residents will receive restorative nursing care as needed to help promote optimal safety and independence" This Federal tag relates to Complaints IN00404282, IN00404286, and IN00401379. 3.1-42(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interviews, and record review, the facility failed to ensure residents environment	F 0689	**It is the practice of Bethel Manor to ensure that residents are free of accidents and**	05/22/2023

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	remained free from accident hazards for 2 of 4 residents reviewed for falls. New interventions were not implemented following falls. (Resident H, Resident 5) Findings include: 1. On 4/19/23 at 11:40 A.M., Resident H was observed wondering the unit in a wheel chair. On 4/18/23 at 2:41 P.M., Resident H's clinical record was reviewed. The diagnoses included, but were not limited to, unspecified dementia and displaced midcervical fracture of left femur. The Quarterly MDS (Minimum Data Set) assessment, dated 3/23/23, indicated Resident H had severe cognitive impairment and required extensive assistance for transferring and dressing. Resident H was a high risk for falls. Resident H's physician orders included, but were not limited to, alarming floor mat, check placement, and functioning every shift, antirollback to wheelchair two times a day for fall reduction measure, and place resident's bed against the wall per family request. Resident H's care plan dated 6/22/22 included, but not limited to: Resident is at high risk for falls per fall risk assessment. The interventions included, but were not limited to, touch pad call light within reach at all time and transfer with extensive assist of 1 to 2. Fall events from 2/6/23 to 4/16/23 Fall 1 - Post Fall Evaluation On 2/6/23 at 3:15 A.M., the resident had an unwitnessed fall that occurred in the resident's		**hazards.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** Resident H's identification was determined due to fall date and time, this gave the facility an identifier as to who the resident is. An intervention was implemented on 2/7/23. IDT determined an intervention of a medication review by Deer Oaks Psychological Services for Resident H. The fall on 3/6/23, according to the nurse's notes, neuro checks were completed at 0438. IDT determined an intervention for Resident H's fall on 4/16/23 of adding anti roll backs to resident's wheelchair. Intervention was applied to the care plan on 4/18/23. Resident 5's care plan was updated to reflect the change in bed location. Resident 5 received Part A therapy services from 2/22/23- 3/5/23 and Part B therapy services from 3/6/23-4/21/23. Resident's care plan was updated to reflect therapy recommendations. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. Nurse managers completed a fall risk assessment on all residents residing in the facility. Any resident that was	

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	room. The CNA went into to the resident's room, heard the floor mat alarm sounding, and found resident sitting on the alarming mat. The resident was noted to also be incontinent. No new interventions were implemented. Fall 2 - Post Fall Evaluation On 3/6/23 at 4:14 A.M., The nurse heard resident floor alarm sounding. As nurse got to residents room, resident was noted standing and fell to floor on buttocks, hitting head on side of bed rail. Light was off. Resident was noted to be incontinent. Resident had no footwear on. Full head to toe skin assessment completed. Resident does have small bump on top of scalp, slight toward right. No neurochecks were documented at this time. Fall 3 - Post Fall Evaluation On 4/16/23 at 5:30 P.M., resident had a witnessed fall in the dining room while trying to transfer from a chair back into wheelchair. She sustained bruising to the left eye brow. The wheel chair was unlocked at the time of the fall. No new interventions were implemented. On 4/20/23 at 1:00 P.M., the DON provided the alarm frequency monitoring for the week for 3/10/23 to 3/17/23. The monitoring was to see if the resident was attempting to self transfer and set off alarms during days and night. - On 3/11/23 day shift was not documented. - On 3/12/23 day shift was not documented. - On 3/13/23 day shift was not documented. - On 3/14/23 night shift was not documented. - On 3/15/23 night shift was not documented. - On 3/16/23 day shift was not documented. During an interview on 4/20/23 at 1:17 P.M., CNA 9 indicated she did not know the fall interventions for the residents off the top of her head off but		identified as high risk was immediately reviewed. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All resident fall care plans and interventions were audited to ensure interventions were in place and up to date. All nursing staff have been educated and in-serviced on fall prevention. Unit nurses have been educated and in serviced on implementation of fall interventions and management team notification. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure the accuracy of resident's fall interventions and care plans and that the above corrective actions and changes are being followed. This tool will be completed by the Administrator or designee, weekly for four weeks, then monthly for three months, then quarterly for three quarters. Any areas identified through this audit will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	could look at her IPAD for the care plan information.2. On 4/19/23 at 9:18 A.M., Resident 5's bed was observed in the middle of the room with only the head of the bed against a wall. On 4/20/23 at 10:58 A.M., CNA 25 indicated that Resident 5 had dementia and would get out of bed and walk to the bathroom or in the halls; however, ever since his fall the staff kept an eye on him, and he didn't try to get up anymore. On 4/21/23 at 10:38 A.M., Resident 5's bed was observed in the middle of the room with only the head of the bed against a wall. At that time, LPN 15 indicated that the bed had been against the wall, but it was difficult to care for Resident 5 with the bed in that position because they needed two people to get him up out of bed. On 4/21/23 at 9:06 A.M., Resident 5's clinical record was reviewed. The diagnoses included, but were not limited to, fracture of neck of left femur and dementia. The most recent Significant Change MDS assessment, dated 2/28/23, indicated Resident 5 required extensive assistance of 2 or more staff with bed mobility and transfers, required total assistance of 1 staff with toileting and bathing, and had a mild cognitive impairment. A current falls care plan, initiated 5/27/22, indicated Resident 5 was at risk for falls. Interventions included, but were not limited to, quarter side rails in bed for mobility enablers (dated 5/27/22), bed placed against wall (dated 12/28/22), call light within reach (dated 5/27/22), environment free of clutter (dated 5/27/22), commonly used articles within easy reach (dated 5/27/22), resident to wear non-skid footwear			

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	(dated 5/31/22), and hoyer lift used for transfers (dated 4/6/23). A current care plan, initiated 5/27/22, indicated Resident 5 had a self-care deficit. Interventions included, but were not limited to, assistance to complete all personal hygiene tasks including bathing, oral care, and dressing (dated 5/27/22). The Quarterly Fall Risk Assessment, dated 9/1/22, indicated Resident 5 was a high risk for falls. Resident 5's falls included: Fall 1: On 12/23/22 at 5:15 A.M., Resident 5 sustained an unwitnessed fall in his bedroom while reaching for his electric razor. The immediate intervention implemented was to place the resident's bed against the wall to allow the resident to be up in a safe position when reaching for personal belongings on his dresser. Fall 2: On 2/15/23 at 5:00 A.M., Resident 5 sustained an unwitnessed fall in his bedroom. Resident 5 indicated he was walking to the bathroom when he started leaning to his left side. He then grabbed onto the bedside table to steady himself; however, the bedside table rolled away from him causing him to fall. At that time, Resident 5 had 3 small round bruises to the bony prominence's of his left elbow. Resident complained of left hip pain upon standing and ambulating, and an order was given for an x-ray. The immediate intervention implemented was to check, change, or assist resident to the toilet as able every 3 hours throughout the night. On 2/16/23 at 1:10 A.M., a follow up fall note indicated the x-ray showed "No acute osseous (bone) abnormality."			

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	On 2/17/23 at 11:15 A.M., Resident 5 was sent to the ER (emergency room) due to a decline in condition. On 2/17/23 at 4:20 P.M., a follow up fall note indicated that the hospital confirmed Resident 5 had a hip fracture. An orthopedic procedure was performed to repair the fracture. Fall 3: On 2/25/23 at 5:25 P.M., Resident 5 sustained a witnessed fall in the hallway. The resident was ambulating unassisted. The resident complained of increased pain and was sent to the ER. The resident returned to the facility at 11:45 P.M. the same day with no new injuries noted. The falls care plan was not updated at that time with a new intervention. On 4/21/23 at 11:01 A.M., LPN 32 indicated that having Resident 5's bed against the wall should have been discontinued because it would be hard to care for the resident with the bed in that position since Resident 5 was a larger person that required total assistance after the fracture. On 4/21/23 at 11:23 A.M., the DON indicated that the care plan should have been updated to reflect the need for total care when Resident 5 returned to the facility on 2/21/23, but the care plan was not updated. A current "Fall Prevention Program Policy" was provided on 4/17/23 at 9:27 A.M. The policy indicated "each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Definition a "fall" is an event in which an individual unintentionally comes to rest on the ground....The event may be witnessed, reported, or presumed			

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	when a resident is found on the floor,... can occur anywhere... Policy explanation and compliance guidelines...7 a... interventions will be monitored for effectiveness. b the plan of care will be revised as needed 8. when any resident experiences a fall the facility will: a. assess the resident...e review the resident's care plan and actions with updates..." 3.1-45(a)(1)			
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on observation, interview, and record review, the facility failed to ensure services of a RN (Registered Nurse) were available at least 8 consecutive hours a day, 7 days a week for 2 of 7 days reviewed for nurse staffing. Findings include: On 4/19/23 at 10:30 A.M., the daily nursing assignment sheets were provided for the week of 4/3/23 through 4/10/23 and reviewed.	F 0727	**It is the practice of Bethel Manor to ensure that there are at least 8 hours of RN coverage daily.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified to be affected by the cited deficient practice.	05/22/2023

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	The sheets indicated there was no RN coverage for Saturday, 4/8/23 and Sunday, 4/9/23. During an interview on 4/21/23 at 4:45 P.M., the Administrator indicated there was not RN coverage for those dates and there should have been 8 hours of consecutive RN coverage every day. On 4/21/23 at 4:45 P.M., a current undated "Nursing Services and Sufficient Staff" policy, was provided by the Administrator and indicated " ... the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week ... " 3.1-17(b)(3)		***Other residents that have the potential to be affected have been identified by:*** No other residents were identified to be affected by the cited deficient practice. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** A Quality Assurance Tool has been developed to ensure that nursing staffing is posted and accurate. A log will be kept and updated by the Director of Nursing or designee. The Scheduler and Human Resources have been in serviced on F727. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that there is at least 8 hours of RN coverage is scheduled daily and that the above corrective actions and changes are being followed. This tool will be completed by the Administrator or designee for 4 weeks, monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any	

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			additional interventions are needed.	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the			

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	posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure the posted nurse staffing sheets included the facility census and actual hours worked for 5 of 5 days during the survey. Findings include: On 4/17/23 at 10:30 A.M., a staffing sheet was observed posted in the front entrance of the facility on the wall to the left of the nurse's station. The posted nurse staffing sheet indicated the facility name, current date, and the number of staff scheduled for the following disciplines: RN (Registered Nurse), LPN (Licensed Practical Nurse), and CNA (Certified Nurse Aide). The facility's current daily resident census and actual hours worked were not included on the posting. On 4/18/23 at 8:58 A.M., the posted nurse staffing was observed. The number of staff on the evening shift included, but was not limited to, 1.5 LPN, 6.5 CNA, and night shift included, but was not limited to, 5.5 CNA and 7.5 total FTE. It lacked the facility's current daily resident census and actual hours worked. On 4/19/23 at 12:06 P.M., the posted nurse staffing was observed. The for indicated a date 4/19, no year indicated. The number of staff on the evening shift indicated was 0.5 RN, 1.5 LPN, 5.75 CNA and 7.75 total FTE and night shift included 1.5 RN, 1.5 LPN, 4.5 CNA, and 7.5 total FTE. It lacked the facility's current daily resident census and actual hours worked. On 4/20/23 at 6:37 A.M., the posted nurse staffing	F 0732	**It is the practice of Bethel Manor to ensure the nursing staffing posting is accurate and in a prominent area.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** No residents were identified as being affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The nursing staffing sheet was updated and two days of the staffing sheets will be posted. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that nursing staffing is posted and accurate. The Scheduler and Human Resources have been in serviced on F732. This tool will be completed by the Administrator or the designee weekly for 4 weeks, monthly for three months, and then quarterly for three quarters.	05/22/2023

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	was observed. The number of staff on the evening shift included, but was not limited to, 0.5 RN and 1.5 LPN. The night shift included, but was not limited to, 1.5 LPN and 6.5 total FTE. It lacked the facility's current daily resident census and actual hours worked was completed. On 4/21/23 at 9:52 a.m., the posted nurse staffing was observed. The number of staff on the evening shift indicated was 0.5 RN, 0.5 LPN . It lacked the facility's current daily resident census and actual hours worked was not completed. On 4/21/23 at 12:04 P.M., the Scheduler indicated the bottom portion of the daily posted staffing form (actual hours worked) was not filled out until the next day so any call in's or changes to the current day's schedule will not be on what was posted, but would be added after that day was completed. At that time, she indicated the current census for the current day should be on the posted form and was put on the forms after the day was completed and the sheet posted at the beginning of the day was who was scheduled, but actual hours were added in after the day was complete. A current "Nurse Staffing Posting" policy, revised October 2022, was provided by the Administrator on 4/21/23 at 3:40 P.M., and indicated " ... 1. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: a. facility name b. the current date c. facility's current resident census d. the total number of staff scheduled and the actual hours worked by thee following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift ... 4 ... b. The actual hours worked should not be completed until following the shift as staffing can vary throughout the shift. The actual		Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	hours worked should be calculated and completed prior to filing the staffing form ... " 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as			
F 0758 SS=D Bldg. 00				

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	provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications for 1 of 1 residents reviewed for hospice. A resident's as needed anti-anxiety medication was ordered for greater than 14 days. (Resident 46) Finding includes: On 4/18/23 at 12:51 P.M., Resident 46's clinical record was reviewed. The diagnosis included, but was not limited to, anxiety. The Significant Change MDS (Minimum Data Set) Assessment, dated 3/21/23, indicated Resident 46's cognition was severely impaired and was currently on hospice. Current physician orders included, but were not limited to: Lorazepam Intensol Oral Concentrate (anti-anxiety medication) 2 MG (milligram)/ML (milliliter). Give 0.25 ml by mouth every 6 hours as needed for anxiety; restlessness related to anxiety disorder, dated 3/13/23. Resident 46's clinical record lacked any physician	F 0758	**It is the practice of Bethel Manor to ensure that residents are free of unnecessary use of psychotropic medications.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** An order was sent to Resident 46's physician for a request to extend the order for the antipsychotic medication and to also include a stop date. ***Other residents that have the potential to be affected have been identified by:*** All residents receiving PRN psychotropic medication have the potential to be affected. A report of residents with orders for psychotropic medication was obtained and reviewed. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:***	05/22/2023

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	155607	A. BUILDING 00 B. WING	04/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHEL MANOR	6015 KRATZVILLE RD EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reassessment for lorazepam after the initial 14 days after it was ordered. The clinical record lacked a care plan addressing the anti-anxiety medication. During an interview on 4/20/23 at 1:23 P.M., the DON indicated Resident 46 did have an order for as needed lorazepam since 3/13/23, that did not have a stop date or an assessment from a physician after 14 days. The DON further indicated that PRN psychotropic medications should have a stop date if continued longer than 14 days. On 4/20/23 at 1:50 P.M., a current Antipsychotic Medication Use policy, revised December 2016, was provided and indicated "The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order." 3.1-48(a)(2)		All residents receiving PRN anti-psychotic medication have been audited and messages sent to physicians for order renewal when appropriate. A psychotropic medication usage care plan was completed for Resident 46 on 4/20/23. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that residents that have an order for a PRN psychotropic medication also have a stop date and physician rationale for usage. This tool will be completed by the Director of Nursing or designee for four weeks, monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when			

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	applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review the facility failed to ensure deteriorated medications carts were disposed of for 2 of 4 medication carts. Loose pills were found in the bottom of the medication cart drawers. (North Hall, South Hall) Findings include: 1. On 4/19/23 at 7:58 A.M., the medication cart on the North Hall was observed to have the following medications laying loose in the bottom of 2 drawers: 1 large white pill #12 1 small round pill with R # 25 1 small round blue pill with no writing 1 small round pill with # 1484 1 oblong peach pill with # 722	F 0761	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No residents were identified in the survey findings. ***Other residents that have the potential to be affected have been identified by:*** No residents were identified as being negatively affected by the cited deficient practice. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** An additional med cart was delivered for the North Hall Unit for	05/22/2023

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	1 small round peach pill with PH # 034 1 small round white pill with #10 1/2 yellow pill could not read number 1 large round white pill with PH #020 1 small round white pill with no writing 1 white capsule with SG #179 1 peach round small pill with #OH 034 1 scored small white pill with # AC 152 1/2 small white pill with #49 1 small round clear orange 1 small oblong white pill with no number 1 large oblong pill with K #46 1 large round white pill with no number 1 small red round pill with PH # 32 1 small round red pill no number 1 crushed white capsule no number 1 reddish brown oblong pill with #12 21 1 large white pill round with TCL # 340 1 small round pill with #210 1 red oblong pill with #796 1 small round white pill with #3040 1/2 white oblong pill no number 1 small multi brown colored pill with # 0140 2. On 4/19/23 at 8:40 A.M., the medication cart in the South hall was observed with the following medications in the bottom of 1 drawer: 1 small white oblong pill with # 6948 1 large oblong yellow pill with #18 1 small red pill with LS # 203 2 large oblong white pills with C#484 1 small round white pill with MP #668 During an interview on 4/19/23 at 8:07 A.M., LPN 42 indicated loose medication found in a drawer should be removed and disposed of into a a bottle of liquid drug disposal. During an interview 4/19/23 at 8:30 A.M., the		overflow to allow for additional space. An audit has been performed of the hall med carts by the pharmacy. A cleaning log has been updated and all nursing staff have been educated on the use of it. The unit nurses have been in serviced on F761. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that all med carts are free from loose pills and debris. This tool will be completed by the Director of Nursing or designee weekly for four weeks, monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	DON, indicated when there were loose medications found in the medication cart drawers, the nurse/QMA (Qualified Medication Aide) immediately placed the pills into the drug buster and notified the DON and Administrator. During an interview on 4/19/23 at 8:45 A.M., LPN 21 indicated many of the pills pop out because the cards are stuffed tightly into the drawers. LPN 21 indicated when she found loose medication in a drawer the pills are placed in the bio hazard sharps container. A current Storage of Medications and Biological's policy, reviewed 5/12/21, was provided by DON on 4/19/21 at 12:30 P.M. The policy indicated "In accordance with State and Federal laws..., the facility must store all medications and biologicals in locked compartments or storage rooms...Procedure... 21. Disposal of medication(s) should be completed for medication(s) that are without secure, outdated, contaminated or deteriorated. a. Disposal needs to be timely...c. Disposal of medication(s) per medication disposal procedure..." 3.1-25(o)			