STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING 00 B. WING	11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE DEMOTTE	10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310

(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 and Investigation of Complaint IN00418505. This visit included a State Residential Licensure Survey. Complaint IN00418505 - Federal/State deficiencies related to the allegations are cited at F584, F677, and F689. Survey dates: October 29, 30, 31, November 1, 2, and 3, 2023. Facility number: 000471 Provider number: 155572 AIM number: 100290390 Census Bed Type: SNF/NF: 64 SNF: 6 Residential: 6 Total: 76 Census Payor Type: Medicare: 3 Medicaid: 36 Other: 31 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/14/23.	F 0000		
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deana Jordan Collins	Regional Nurse Consultant	12/08/2023

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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	The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.			

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	Based on record review and interview, the facility failed to ensure an inventory record of a resident's property was provided to a resident and/or the resident's representative on admission or discharge from the facility for 1 of 1 residents reviewed for personal property. (Resident B) Finding includes: Record review for Resident B was completed on 10/30/23 at 2:02 p.m. Diagnoses included, but were not limited to, hypertension, diabetes mellitus, and dementia. The resident admitted to the facility on 8/23/23 and discharged on 9/25/23. The Admission Minimum Data Set (MDS) assessment, dated 8/28/23, indicated the resident was cognitively impaired. A Nurse's Note, dated 9/25/23 at 2:30 p.m., indicated the resident's son called and requested his dad be dressed and up in his chair around 4:00 p.m. and then hung up the phone. The last progress note in the resident's record was a Social Service Note, dated 9/26/23 at 10:00 a.m., that indicated she spoke with APS (Adult Protective Services) in regards to inappropriate discharge for Resident B. There was no documentation to indicate the resident or his family took any of his belongings when he left the facility. Interview with the Social Services Director (SSD) on 10/31/23 at 1:48 p.m., indicated the resident' son called and asked Nursing to have the resident ready and he was going to pick him up. The son picked him up and didn't bring him back. The resident had discharged AMA (against medical	F 0584	**Tag number: F584** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B no longer resides at the facility. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff, admissions staff will be educated on the policy “Release of a Residents Personal Effects” to include the importance of completing an inventory sheet and providing a copy to the resident/responsible party upon discharge. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee will audit new admissions to ensure an inventory sheet has been completed and all discharges to home/another facility to ensure a copy of the sheet was provided to the residents/RP. Audits will be completed 5x week for 4 weeks, 2x week for 4 weeks then weekly	12/02/2023

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	advice). The son did not take any of the residents belongings. The next day, the residents daughter came in and picked up the resident's belongings. The SSD was unable to find if the resident had an inventory sheet completed on admission nor did the daughter sign anything for which belongings she received when she picked up the resident's things. Interview with the Administrator on 10/31/23 at 2:35 p.m., indicated the facility usually completed an inventory list when residents were admitted. The staff should have had an inventory sheet completed with the resident's belongings listed so the family could have signed the sheet when they picked up his belongings. A facility policy titled, "Release of a Resident's Personal Effects", received as current from the facility on 10/31/23, indicated, "...3. Individuals receiving the resident's personal effect will be required too sign a release for such items 4. Documentation of the disposal of the resident's personal effects must be filed in the resident's medical record..." This citation relates to complaint IN00418505. 3.1-9(g)		x 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 12/02/23	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.			

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	(B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to ensure care plan meetings were completed quarterly and/or included the family and IDT (interdisciplinary team) members as required for 2 of 19 residents reviewed for care planning. (Residents E and 5) Findings include: 1. Resident E's record was reviewed on 10/31/23 at 9:12 a.m. Diagnoses included, but were not limited to, Diabetes Mellitus and vascular dementia. The Quarterly Minimum Data Set assessment, dated 7/21/23, indicated the resident had severe cognitive impairment and required substantial/ maximum assistance for bed mobility and transfers.	F 0657	**Tag number: F657** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident E had a care plan meeting held on 11/25/23 with family and IDT. Resident 5 has a care plan meeting on 11/16/23 with family and IDT. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. SSD educated on the	12/02/2023

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	There was no documentation a quarterly care plan meeting had been completed since November 2022. Telephone interview on 11/1/23 at 9:46 a.m. with the resident's health care representative, indicated she had not been invited to or attended a care plan meeting in about a year. Prior to that, she had been invited regularly. A copy of the last invitation to the health care representative was provided by the Social Service Director (SSD) and was post marked 10/25/22. Interview with the SSD on 11/1/23 at 10:15 a.m., indicated the last care plan meeting for the resident was on November 7, 2022. She indicated she had no additional information why there had been no quarterly care plan meetings since. 2. During an interview with Resident 5 on 10/29/23 at 11:16 a.m., the resident indicated she was not familiar with care plan meetings and hadn't been to one since she came to the facility. The record for Resident 5 was reviewed on 10/31/23 at 9:00 a.m. Diagnoses included, but were not limited to, anxiety disorder, polyneuropathy, abdominal hernia without obstruction or gangrene, major depressive disorder, bipolar disorder, and chronic obstructive pyelonephritis. The Quarterly Minimum Data Set (MDS) assessment, dated 8/6/23, indicated the resident was cognitively intact. A Care Plan Note, dated 5/29/19, indicated 5/29/19 was the last documented care plan meeting for Resident 5. IDT (interdisciplinary team) had met with the resident and her daughter. The care plans		policy “Comprehensive Care Plan” and the importance of including family and IDT in meetings The MDS schedule for the last 30 days was reviewed to ensure care plan meetings were held with family/IDT or scheduled when applicable. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; SSD/designee to schedule care plan meetings with quarterly MDS schedules to include family/IDT. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee to audit quarterly MDS schedule to ensure care plans are being held with family/IDT. Audits will be completed on 5 residents a week x 4 weeks, 3 residents a week x 4 weeks, 1 resident a week x 4 weeks, then 1 resident a month x 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 12/02/23	

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	were reviewed, discussed, and updated. Interview with the Social Service Director on 11/1/23 at 10:08 a.m., indicated the last care plan invitation sent to Resident 5's daughter was dated for 11/28/22. The daughter did not respond. Interview with the Social Service Director on 11/1/23 at 10:33 a.m., indicated typically when a response was not given by the family, she didn't hold the care plan meeting. She would send out an invite to the family for the next care conference. A facility policy titled, "Comprehensive Care Plan" and provided by the Director of Nursing as current, indicated, "The resident and/or resident representative shall be invited to review the plan of care with the interdisciplinary team either in person, via telephone or video conference [if available] at least quarterly". 3.1-35(d)(2)(B)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure dependent residents received the ADL (activities of daily living) assistance needed related to uncut, dirty fingernails for 2 of 3 residents reviewed for ADL care. (Residents D and E) Findings include: 1. On 10/30/23 at 11:29 a.m., Resident D was	F 0677	**Tag number: F677** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents D and E had their fingernails cleaned and trimmed. II. How other residents having the potential to be affected by the same deficient practice will be	12/02/2023

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	observed seated in his room. His fingernails were long and some were broken and jagged. On 10/31/23 at 10:28 a.m., the resident was observed seated in his room, his nails were still long and jagged. The resident's record was reviewed on 10/31/23 at 10:17 a.m. Diagnoses included, but were not limited to, osteoarthritis of the knee and frequent falls. The Quarterly Minimum Data Set assessment, dated 10/4/23, indicated the resident had significant cognitive impairment and required partial/ moderate assistance for eating, transfers and toileting. Interview with CNA 1 on 10/31/23 at 11:13 a.m., indicated staff did resident fingernail care on Sundays. She was unable to locate documentation the resident had nail care recently, but would complete it today. 2. On 10/29/23 at 9:42 a.m., Resident E was observed in bed eating breakfast. His fingernails were uncut and had dark debris under them. On 10/31/23 at 8:50 a.m., the resident was observed in bed, his fingernails were still uncut and dirty. The resident's record was reviewed on 10/31/23 at 9:12 a.m. Diagnoses included, but were not limited to, Diabetes Mellitus and vascular dementia. The Quarterly Minimum Data Set assessment, dated 7/21/23, indicated the resident had severe cognitive impairment and required substantial/ maximum assistance for bed mobility and transfers.		identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; **DON/designee to educate nursing staff on performing ADL care to include trimming and cleaning of fingernails.** IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct an ADL audit to ensure ADL care, including trimming and cleaning of fingernails, is being rendered per residents POC. Audits will be completed on 5 residents a week for 4 weeks, 3 residents a week for 4 weeks then 3 residents a month x 4 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the	

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	The October 2023 shower sheets were marked "No" for nail care provided on all days except 10/13 and 10/27, which were left blank. Interview with CNA 1 on 10/31/23 at 11:13 a.m., indicated the resident would frequently eat with his fingers and debris would accumulate quickly. She would provide nail care today. This citation relates to Complaint IN00418505. 3.1-38(3)(E)		plan of correction as indicated. Date of compliance: 12/02/23	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure a resident received treatment of edema related to compression stockings not in place, a skin discoloration was assessed and monitored, and a Physician's Order was in place for a resident with a back brace for 1 of 2 residents reviewed for edema, 1 of 2 residents reviewed for non-pressure skin conditions and 1 of 2 residents reviewed for positioning and range of motion. (Residents D, 57 and 220) Findings include: 1. On 10/30/23 at 11:29 a.m. and 10/31/23 at 10:28	F 0684	**Tag number: F684** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident D had his compression stockings discontinued, Resident 57 had the discoloration to hands assessed on 10/30/23 , Resident 220 received an order for the back brace on 10/30/23. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	12/02/2023

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	a.m., Resident D was observed seated in his room. He had on two pair of regular socks and shoes, there were no compression socks worn. The resident's record was reviewed on 10/31/23 at 10:17 a.m. Diagnoses included, but were not limited to, osteoarthritis of the knee and frequent falls. The Quarterly Minimum Data Set assessment, dated 10/4/23, indicated the resident had significant cognitive impairment and required partial/ moderate assistance for eating, transfers and toileting. The current Edema Care Plan indicated the resident had edema to bilateral lower extremities. Interventions included to wear elastic stockings (TED hose). The Tasks in the electronic record indicated the resident was to have TED hose applied to bilateral lower extremities, on in the morning and removed at night. There was no documentation it had been completed in the past 30 days. Interview with CNA 1 on 10/31/23 at 11:13 a.m., indicated the CNAs were responsible for applying the TED hose. The resident did not like to wear them, and there was no charting related to the resident wearing or refusing TED hose. 2. On 10/29/23 at 10:58 a.m. Resident 57 was observed lying in bed. There were multiple dark purple discolorations to the tops of both hands. There were no protective sleeves in place. On 10/30/23 at 3:00 p.m. Resident 57 was seated in his wheelchair outside his room. There were multiple dark purple discolorations to the tops of both hands. There were no protective sleeves in		action(s) will be taken; All resident have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure any resident with an order for compression stockings had their stockings in place, and any resident with a brace had an order in place. A full house skin sweep was completed to ensure any areas of discolorations have been assessed. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee will educate nursing staff on the policy “Skin Condition Assessment & Monitoring-Pressure and Non-Pressure" and following a physician orders IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will conduct an audit to ensure all braces, stockings and bruises have been addressed, including orders for braces, stockings (removal and assessment of skin condition) and monitoring of bruises. Audits will be completed on 5 residents a week for 4 weeks, 3 residents a week for 4 weeks then 3 residents a month x 4 months.**	

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	place. On 11/1/23 at 11:53 a.m. Resident 57 was lying in bed. The multiple dark purple discolorations remained to the tops of both hands. There were no protective sleeves in place. Record review for Resident 57 was completed on 11/1/23 at 10:13 a.m. Diagnoses included, but were not limited to, atrial fibrillation, congestive heart failure, and vascular dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 10/4/23, indicated the resident was cognitively impaired and dependent on staff for ADLs (activities of daily living). A Care Plan, dated 10/16/23, indicated the resident had a skin tear to his right back hand and right forearm. An intervention included ".... resident needs protective sleeves for the bilateral arms and tops of hands ...." A Skin Condition Report, dated 10/13/23, indicated the resident had a small scratch and skin tear to the right back hand and a skin tear to the right forearm. The Weekly Skin Observations, dated 10/23/23 and 10/30/23, indicated the resident's skin was intact and there were no concerns. There was a lack of documentation of the discolored areas to the tops of both hands. The Medication Administration Record, dated 10/2023, indicated the resident received Xarelto (an anticoagulant medication) 10 mg (milligrams) daily. Interview with the Interim Director of Nursing on		The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 12/02/23	

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	11/2/23 at 8:44 a.m., indicated the discolorations were probably missed and should have been documented. A facility policy, titled "Skin Condition Assessment & Monitoring-Pressure and Non-Pressure", received as current, indicated "...Non pressure skin conditions (bruises/contusions, abrasions, lacerations, rashes, skin tears, surgical wounds etc) will be assessed for healing progress and signs of complications or infection weekly...A wound assessment will be initiated and documented in the resident chart when pressure and/or other non pressure skin conditions are identified by licensed nurse...Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment..." 3. On 10/30/23 at 11:05 a.m., Resident 220 was observed seated in his wheelchair near the Nurse's Station. He had a black back brace in place over his chest and back. On 10/30/23 at 1:31 p.m., Resident 220 was observed seated in his wheelchair near the Nurse's Station. He had a black back brace in place over his chest and back. Record review for Resident 220 was completed on 10/30/23 at 1:43 p.m. Diagnoses included, but were not limited to, wedge compression fracture of the third lumbar vertebra and anemia. The Quarterly Minimum Data Set (MDS) assessment, dated 10/1/23, indicated the resident was cognitively impaired and dependent on staff for ADLs (activities of daily living).			

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	155572	A. BUILDING 00 B. WING	11/03/2023

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	A Care Plan, dated 9/28/23, indicated the resident had an L3 compression fracture and a back brace was to be worn when out of bed. The Physician's Order Summary, dated 10/2023, lacked any orders for a back brace, guidance on when the resident should wear it, or monitoring to the skin under the brace. Interview with the Interim Director of Nursing on 10/30/23 at 2:50 p.m., indicated there should have been an order in place for the back brace. 3.1-37(a)			
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 observation, record review, and interview, the facility failed to ensure fall interventions were in place for a resident with a history of falls for 1 of 4 residents reviewed for falls. (Resident C) Finding includes: On 10/30/23 at 10:00 a.m. and 10/31/23 at 10:29 a.m., Resident C's bed was observed. It was a standard mattress without bolsters.	F 0689	**Tag number: F689** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident C's fall care plan interventions were reviewed and revised as needed. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All	12/02/2023

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	On 10/31/23 at 11:27 a.m., the resident was seated in the activity room. CNA 1 assisted the resident to a standing position from her wheelchair. There was a cushion in place, but there was not a Dycem (a non slip device for chairs) in place on the chair. The CNA indicated she thought the Dycem was in place, but it was not. The resident's record was reviewed on 10/30/23 at 2:35 p.m. Diagnoses included, but were not limited to, Parkinson's disease, difficulty walking, and repeated falls. A Progress Note, dated 10/24/23, indicated the resident had a witnessed fall in the bathroom attempting to self transfer. A Progress Note, dated 10/28/23, indicated the resident had an unwitnessed fall and was found lying on the floor next to her bed. The current Fall Care Plan indicated the resident was at high risk for falls related to impaired balance/ mobility, poor posture in wheelchair, multiple fractures and a history of falls. Interventions included a bolster mattress to the bed and a Dycem on the wheelchair. On 10/31/23, the Director of Nursing was made aware the above fall interventions were not in place. There was no additional information provided. This citation relates to Complaint IN00418505. 3.1-45(a)		residents at risk for falls have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure all fall interventions are in place. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nursing staff/ Guardian Angels on ensuring all fall interventions are in place as per POC. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will audit 5 resident rooms a week, 4 weeks, 3 resident rooms a week x 4 weeks, 1 resident room a week x 4 weeks, then 1 resident room a month x 3 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 12/02/23	
F 0693 SS=D	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills			

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Bldg. 00	§483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure Physician's Orders were in place for feeding tube maintenance and a feeding bag was changed daily for 1 of 1 residents reviewed for tube feeding. (Resident 119) Finding includes: On 10/29/23 at 9:47 a.m., Resident 119 was observed in bed. He was non-responsive, had a trachea with oxygen flowing and tube feeding connected and running. The bag with the feeding solution was noted to have dried, clumpy solution on the inside sides of the bag and the date had been covered with a black marker. The date underneath the black marker was visible and	F 0693	**Tag number: F693** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 119 no longer resides at the facility. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Any resident receiving enteral nutrition has the potential to be affected by the alleged deficient practice. An audit was completed on all residents receiving enteral feedings to ensure all orders were	12/02/2023

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	indicated 10/24/23. On 10/29/23 at 2:40 p.m., the tube feeding was observed with the Nurse Consultant, it was still hanging and running. The Nurse Consultant indicated she could see the date beneath the black marker and she would look into it. The resident's record was reviewed on 10/30/23 at 1:15 p.m. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia, persistent vegetative state and cerebral infarction. The resident was admitted on 9/21/23, sent to the hospital on 9/25/23, and readmitted on 10/5/23. The Admission Minimum Data Set assessment, dated 10/9/23, indicated the resident's cognition was unable to be assessed and he was dependant on staff for bed mobility, transfers, toileting and eating. The resident received hospice services. A Physician's Order, dated 10/11/23, indicated the resident received Glucerna 1.2 (tube feeding solution) at 90 milliliters an hour for 22 hours a day. On at 7:00 a.m., and turned off at 5 a.m. A Physician's Order, dated 9/21/23, indicated to change the intermittent feeding set every 24 hours. The order had been discontinued on 10/5/23. There was no current order for changing the intermittent feeding set. Interview with LPN 1 on 10/29/23 at 2:38 p.m., indicated she was going to change the feeding bag but did not have any bags compatible with that pump. She had contacted hospice about getting more bags. She was unsure when it had last been changed. The bags were supposed to changed daily.		present and being followed. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee will educate nurses on ensuring all orders are present and followed for any resident receiving enteral feedings. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will audit all new orders for enteral feeding to ensure all pertinent orders are present and being followed. Audits will be completed 5x week x 4 weeks, 3x week for 4 weeks, weekly x 4 weeks then monthly x 3 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 12/02/23	

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	3.1-44(a)(2)			
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 posted daily nurse staffing data for a			

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	minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to have daily nurse staffing postings. This had the potential to affect all 70 residents residing in the facility. Finding includes: On 10/29/23 at 9:35 a.m., the Nursing Staff Sheet was posted at the front entryway on top of a desk. The sheet was dated October 27, 2023. On 11/2/23 at 1:06 p.m., the Payroll Based Journal (PBJ) Staffing Data Report for Quarter 3 2023 (April 1-June 30) was reviewed. It had triggered submitted weekend staffing data was excessively low. The daily Nursing Staff Sheets were reviewed for April 1- June 30, 2023 and October 2 - November 1, 2023. There were no daily sheets for the following days: April 2023 -Saturdays: 4/1, 4/8, 4/15, 4/22, and 4/29/23 -Sundays: 4/2, 4/9, 4/16, 4/23, and 4/30/23 May 2023 -Saturdays: 5/6, 5/13, 5/20, and 5/27/23 -Sundays: 5/7, 5/14, 5/21, and 5/28/23 June 2023 -Saturdays: 6/3, 6/10, and 6/17/23 -Sundays: 6/4, 6/11, and 6/18/23 October 2023 -Saturdays: 10/7, 10/14, 10/21, and 10/28/23 -Sundays: 10/8, 10/15, and 10/22/23	F 0732	**Tag number: F732** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; /b> II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The facility Staffing Coordinator and concierge educated on the importance of the daily nurse staffing sheet being posted every day, including weekends. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The administrator will educate staffing coordinator and concierge on posting the daily nurse staffing sheet 7 days a week. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; /b> The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	12/02/2023

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	Interview with the Administrator on 10/29/23 at 9:58 a.m., indicated the Nurse Staffing Posting should have been updated daily since 10/27/23. Interview with Interim Director of Nursing on 11/2/23 at 2:34 p.m., indicated they could not find the Nursing Staff Sheets were completed for the above dates.		Date of compliance: 12/02/23	
F 0805 SS=E Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation, record review, and interview, the facility failed to ensure food was prepared in form to meet individual needs related to not following a recipe for pureed food or making pureed food the correct consistency. This had the potential to affect all 4 residents who received a pureed diet. Finding includes: On 11/1/23 at 11:10 a.m., Cook 1 was observed preparing pureed food. She indicated she was going to puree tacos. There was no recipe out for reference. She measured 5 scoops of taco meat and placed it in the blender and pureed. She then placed the meat in a prepared serving pan and put it on the steam table. The taco meat looked dry and chunky, not smooth. There were no additional ingredients added to the mixture. She indicated it was completed.	F 0805	**Tag number: F805** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No resident had any adverse outcomes related to the alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Any resident receiving an altered diet has the potential to be affected by the alleged deficient practice. Cook 1 was educated on the policy “Pureed Food Preparation.” III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Dietary Manager/designee will educate cooks on the policy	12/02/2023

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	The Dietary Manager (DM) observed the meat and indicated it was not smooth, it should be creamier. She also indicated it should not be just meat, but the whole taco that was pureed. At 11:40 a.m., the pureed taco mixture was observed. It was creamier and smoother. The Cook indicated she had just added liquid to the meat, she had not remade the pureed tacos with whole tacos. The DM was notified at that time the Cook had not remade the pureed tacos, only added liquid to the meat mixture. She indicated she thought the Cook had remade them and she would inservice the staff. The recipe for pureed tacos was soft beef taco (with no lettuce or tomato), water, beef base and picante sauce. The recipe for beef soft tacos was taco meat (ground beef, water, taco seasoning, onion), flour tortilla shell, shredded lettuce, shredded cheddar cheese and diced tomato. The current policy, "Pureed Food Preparation", was received from the DM indicated, " ...2. Standardized recipes will be used to prepare all pureed foods ..." and, " ...6. Pureed foods will be the consistency of applesauce or smooth mashed potatoes ..." 3.1-21(a)(3)		"Pureed Food Preparation" to include following the pureed recipe and getting the correct consistency. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Dietary Manager/designee to observe staff preparing pureed food to ensure the recipe is being followed. . Audits will be conducted 5x a week x 4 , 2x a week x 4 weeks, 2x a week x 4 weeks, then monthly x 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 12/02/23	
F 9999 Bldg. 00	3.1-25 Pharmacy services	F 9999	**Tag number: 9999** I. What corrective action(s) will be	12/02/2023

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	(b) The administration of drugs and treatments, including alcoholic beverages, nutrition concentrates, and therapeutic supplements, shall be as ordered by the attending physician and shall be supervised by a licensed nurse as follows: (8) Per required need (PRN) medications may be administered only upon authorization of a licensed nurse or physician. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. This State rule was not met as evidenced by: Based on record review and interview the facility failed to ensure a QMA (Qualified Medication Aide) received prior authorization from a licensed nurse before administering a PRN (as needed) medication to a resident for 1 of 1 resident reviewed for hospice. (Resident 219) Finding includes: Resident 219's record was reviewed on 10/31/23 at 2:03 p.m. Diagnoses included, but were not limited to, atrial fibrillation and pneumonia. The Physician's Order Summary, dated 10/2023, indicated orders for ondansetron 4 mg (milligrams) by mouth every 8 hours PRN for nausea and vomiting, morphine sulfate 20 mg/ml (milliliter) 0.5 ml sublingual every 2 hours PRN for pain or shortness of breath, and lorazepam 2 mg/ml 0.5 ml sublingual every 2 hours PRN for agitation or anxiety. The Medication Administration Record (MAR), dated 10/2023, indicated the resident was given		accomplished for those residents found to have been affected by the deficient practice; Resident 219 had no adverse outcomes related to the alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee will educate nurses and QMA's on PRN medication administration. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; **DON/designee will audit PRN medication administration to ensure the proper procedure was followed. Audits will be completed on 5 residents a week x 4 weeks, 3 residents a week x 4 weeks, 1 resident a week x 4 weeks then 1 resident a month x 3 months.** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA	

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	ondansetron on 10/27/23 at 7:24 p.m. by QMA 1, morphine on 10/29/23 at 7:36 p.m. from QMA 2, lorazepam on 10/29/23 at 7:37 p.m. by QMA 2, and lorazepam on 10/31/23 at 12:19 p.m. by QMA 2. There were no EMAR (electronic medication administration record) notes or documentation to indicate a Nurse had assessed the resident or given authorization to administer the PRN medications. Interview with the Interim Director of Nursing on 10/31/23 at 2:59 p.m., indicated the QMAs were supposed to get authorization from the Nurse for any PRN medications and document it in the EMAR notes.		Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 12/02/23	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: October 29, 30, 31, November 1, 2, and 3, 2023. Facility number: 000471 Residential Census: 6 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 11/14/23.	R 0000		
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the			

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	twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure there was one staff member with a current CPR certificate for 20 of 21 shifts reviewed and first aid certificate for 18 of 21 shifts reviewed. This had the potential to affect all 6 residents residing in the facility. Finding includes: Facility staffing schedules for 10/28/23 through 11/3/23 were reviewed on 11/2/23 at 2:00 p.m. The schedules indicated there were no staff members who were CPR certified on the following dates and shifts: Day shift on 10/28/23, 10/29/23, 10/30/23, 10/31/23, 11/1/23, 11/2/23, and 11/3/23. Evening shift on 10/28/23, 10/29/23, 10/31/23,	R 0117	**Tag number: R117** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Moving forward, at least 1 staff member per shift will have first aid certifications. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. At least one staff member per shift will obtain their First Aid certifications. III. What measures will be put into	12/02/2023

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	155572	A. BUILDING 00 B. WING	11/03/2023

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	11/1/23, 11/2/23, and 11/3/23. Midnight shift on 10/28/23, 10/29/23, 10/30/23, 10/31/23, 11/1/23, 11/2/23, and 11/3/23. The schedules indicated there were no staff members who were first aid certified on the following dates and shifts: Day shift on 10/28/23, 10/29/23, 10/31/23, 11/1/23, 11/2/23, and 11/3/23. Evening shift on 10/28/23, 10/29/23, 11/1/23, 11/2/23, and 11/3/23. Midnight shift on 10/28/23, 10/29/23, 10/30/23, 10/31/23, 11/1/23, 11/2/23, and 11/3/23. Interview with the Interim Director of Nursing on 11/2/23 at 8:44 a.m., indicated she was aware the staff CPR and first aid certificates were not up to date.		place and what systemic changes will be made to ensure that the deficient practice does not recur; Staffing Coordinator will be educated on ensuring at least 1 staff member per shift has an active first aid certification. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Administrator/designee will audit the weekly schedule to ensure at least 1 first aid certified staff member is scheduled per shift. Audit will be conducted weekly x 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 12/02/23	
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: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the			

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	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 record review and interview, the facility failed to ensure a medication self-administration evaluation was completed for residents who were self-administering medications for 2 of 7 residents reviewed. (Residents 2 and 7) Findings include: 1. Record review for Resident 2 was completed on 11/3/23 at 9:28 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension and bipolar. A Service Plan, dated 9/1/22 and revised on 6/7/23, indicated the resident required staff to administer his medications. A Physician's Order, dated 1/12/23, indicated ipratropium-albuterol solution (breathing treatment medication), to inhale 3 ml (milliliters) every 12 hours. Unsupervised self-administration and may keep at bedside and self administer. A Medication Self Administration Assessment, dated 10/20/22, indicated the resident was unable to self administer medication. The resident would get confused with names. Interview with Interim Director of Nursing (DON) on 11/3/23 at 12:44 p.m., indicated they had not completed a medication self administration assessment for the resident until 11/3/23. 2. Resident 7's closed record was reviewed on	R 0216	**Tag number: R216** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents 2 and 7 had medication self-administration assessments completed II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. A full house audit was completed to ensure any resident who is deemed safe to self-administer medications has an assessment in place to do so. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nurses were educated on completing an assessment on medication self-administration on any resident who is deemed safe to do so.="" span="">> IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance	12/02/2023

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	11/3/23 at 10:24 a.m. Diagnoses included, but were not limited to, hypertension, diabetes mellitus, and acute right heart failure. He was admitted to the facility on 3/24/23 and discharged on 7/1/23. The Medication Administration Record (MAR), dated 6/2023, indicated the resident self-administered the following medications: stiolto respimat inhaler, saline nasal spray, albuterol sulfate inhaler, and fluticasone nasal spray. These medications had orders that indicated the resident may self administer and keep at bedside. A Service Plan, dated 4/3/23 and signed by the resident on 6/7/23, indicated he required staff to complete administration of all medications. An Assisted Living Functional Assessment, dated 6/7/23, indicated he required staff to complete administration of all medications. There was a lack of any self-administration of medications assessment. Interview with the Interim Director of Nursing on 11/3/23 at 12:52 p.m., indicated she was unable to provide any documentation that a self-administration assessment had been completed.		program will be put into place; **="" span="">**DON/designee will audit med self-administration assessments to ensure any resident who is deemed safe to self-administer has an updated assessment in place. These audits will be completed weekly x 3 months. **="" b="">** The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 12/02/23	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual			

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	resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to ensure a Service Plan was revised and updated to include contracted services and self medication administration for 1 of 7 resident Service Plans reviewed. (Resident 2) Finding includes: Record review for Resident 2 was completed on 11/3/23 at 9:28 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension and bipolar. A list of residents who received contracted services was received by the facility. The list indicated Resident 2 received services from a	R 0217	**Tag number: R217** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 2's service plan was updated to reflect the use of outside services and med self-administration II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. SSD educated on	12/02/2023

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	Home Health Care. A Physician's Order, dated 1/12/23, indicated ipratropium-albuterol solution (breathing treatment medication), to inhale 3 ml (milliliters) every 12 hours. Unsupervised self-administration and may keep at bedside and self administer. A Medication Self Administration Assessment, dated 10/20/22, indicated the resident was unable to self administer medication. The resident would get confused with names. A Service Plan, dated 9/1/22 and revised on 6/7/23, indicated the resident required staff to administer his medications. There was no indication the resident received any services from outside companies. Interview with the Social Services Director on 11/3/23 at 10:20 a.m., indicated the resident received services from a caregiver from VA (Veterans Affairs) twice a week. She would assist him with bathing and a few household chores. The Service Plan should have included the resident was receiving services from an outside company. Interview with the Interim Director of Nursing on 11/3/23 at 12:52 p.m., indicated the Service Plan should have included the resident was administering a medication by himself and that he received services from a caregiver from the VA.		updating service plans to include outside companies and medications self-administration III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; SSD educated on updating service plans to include outside companies and medications self-administration IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; SSD/designee will audit the daily order listing to ensure any resident who has outside services and/or can self-administer meds has an updated service plan to reflect the same. Audits will be completed once a week x 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 12/02/23	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the			

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	following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the Emergency Binder had complete information for residents for 4 of 5 resident records reviewed. (Residents 2, 3, 5 and 6) Finding includes: On 11/3/23 at 10:50 a.m., the facilities Emergency Binder was reviewed. The following items were missing: Resident 2 - no photograph. Resident 3 - no emergency contact phone number. Resident 5 - no photograph or hospital preference. Resident 6 - no photograph or hospital preference. On 11/3/23 at 1:15 p.m., the Director of Nursing was made aware of missing items from the Emergency Binder and had no additional	R 0356	**Tag number: R356** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 2, 3, 5 and 6 had their clinical records updated II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nursing staff, SSD and admission coordinator on the required information needed on a residents	12/02/2023

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	information.		clinical record IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee to audit new admissions to ensure all required information is on residents face sheet to include: hospital preference, photo and emergency contact. SSD will audit emergency binder to ensure all face sheets are up to date. Audits will be completed weekly x 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 12/02/23	