DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155188	A. BUILDING 00 B. WING	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD HEALTHCARE CENTER	200 GREEN MEADOWS DR GREENFIELD, IN 46140

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00348394. Complaint IN00348394 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-558 & F-689. Survey dates: April 26, 27, 28, 29, 30 and May 3, 2021 Facility number: 000099 Provider number: 155188 AIM number: 100291140 Census Bed Type: SNF/NF: 103 Total: 103 Census Payor Type: Medicare: 4 Medicaid: 76 Other: 23 Total: 103 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 11, 2021	F 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law.** **The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual/Complaint Survey conducted April 26, 27, 28, 29, 30 and May 3, 2021. Please accept this plan of correction as the provider's credible allegation of compliance.** **The facility would like to respectfully request a desk review.** **Thank you,** **Andrew Clark, LNHA**	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, interview and record review, the facility failed to promote the diginity	F 0550	**F550 Resident Rights/Exercise of Rights**	06/02/2021

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	of a resident while being assisted with meal intake by standing over the resident while assisting with dining during 1 of 4 dining observations conducted in 3 dining areas of the facility. (Resident 19, LPN 4) Findings include: During a dining observation on 4-26-21 at 11:42 a.m., in the advanced memory care unit, LPN 4 was observed to be assisting Resident 19 with her meal. LPN 4 was observed to stand to the right of Resident 19 during the entire time she assisted the resident with her lunch. An empty chair was observed immediately to the right of LPN 4 during the initial portion of the meal. The unused chair was later moved and used by another staff member who was assisting another resident. In an interview on 4-26-21 at 12:10 p.m., with LPN 4, she indicated, "Normally, I would sit down to feed any resident, but I was afraid one of the residents would be sitting in the the chair here and I didn't want to take their seat away from them." The clinical record of Resident 19 was reviewed on 5-3-21 at 1:04 p.m. Her diagnoses included, but were not limited to Alzheimer's disease, unspecified dementia without behavioral disturbance, diabetes anxiety and depression. Her most recent Minimum Data Set (MDS) assessment, dated 2-18-21, indicated she is dependent of one person for eating. 3.1-3(a) 3.1-3(t)		**Corrective action for the resident(s) found to have been affected by the deficient practice:** Resident #19 no longer resides in the facility. LPN #4 has received education regarding resident rights and maintaining the resident's dignity while providing assistance during meal service. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents requiring assistance to consume their meals have the potential to be affected by the deficient practice An audit to identify residents requiring assistance to consume their meals has been completed and observations made to ensure their dignity has been maintained while receiving assistance to consume their meals. Any identified concerns were immediately addressed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Designee have completed education with nursing staff regarding "Resident Rights" as it relates to maintaining the resident's dignity while assisting the resident to consume their meals.	

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			Corrective actions to be monitored to ensure the deficient practice will not recur: The Director of Nursing/Unit Manager/Designee will audit residents requiring assistance to consume their meals to ensure dignity is maintained. The audit will occur as follows: 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, then 1 resident per week x 4 weeks for no less than 3 months and compliance is maintained. Any identified concerns will immediately be addressed. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record review, the facility failed to ensure a call light was within reach for 1 of 4 residents reviewed	F 0558	**F 558 Reasonable Accomodations Needs/Preferences** **Corrective action for the**	06/02/2021

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	for accommodation of needs. (Resident E) Findings include: The clinical record for Resident E was reviewed on 5/3/21 at 11:58 a.m. The diagnoses included, but were not limited to, traumatic brain injury, quadriplegia and chronic respiratory failure. A communication care plan, revised 10/7/20, indicated to keep Resident E's call light in reach as an intervention. Observations were conducted to where Resident E's call light was not in reach on the following date(s)/time(s): 4/29/21 at 11:56 a.m.- call light clipped to the privacy curtain, 4/29/21 at 2:45 p.m.- call light clipped to the privacy curtain, 4/29/21 at 3:30 p.m.- call light clipped to the privacy curtain, 4/29/21 at 3:55 p.m.- call light clipped to the privacy curtain & 4/30/21 at 10:45 a.m.- call light clipped to the privacy curtain. An observation conducted on 4/30/21 at 2:23 p.m., noted Resident E sitting in the recliner with the call light clipped to her blanket and within reach. An interview conducted with the Director of Nursing (DON), on 5/3/21 at 2:50 p.m., indicated the call light should be within reach. A policy titled "Call Lights: Signaling Device", dated 5/3/21, was provided by the Executive Director on 5/3/21 at 1:43 p.m. The policy		**resident(s) found to have been affected by the deficient practice:** Resident E continues to reside at the facility. Resident E's call light was immediately verified that it was within reach and functional. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the deficient practice. All resident rooms were checked to verify call lights were within reach on 4/30/21 with no further findings. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Designee have completed education with facility staff regarding “Call light and Signaling Devices” . **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/Unit Manager/Designee will audit call light placement. The audit will occur as follows: 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, then 1 resident per week x 4 weeks for no less than 3 months and compliance is maintained. Any	

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	indicated the following, "...Policy...1. Call lights/signaling devices will be within a resident's reach at all times...." This Federal tag relates to Complaint IN00348394. 3.1-3(v)(1)		identified concerns will immediately be addressed. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.			

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	(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on interview and record review the facility failed to have care plan meetings for residents and their families to ensure person centered care was being provided for 4 of 4 residents reviewed for care plan meetings (Resident 17, Resident 31, Resident C and Resident 79). Findings include: 1.) During an interview with Resident 17 on 4/27/21 at 10:48 a.m., indicated she nor her family had ever been invited to a care plan meeting. Review of the record of Resident 17 on 4/28/21 at 11:30 a.m., indicated the resident's diagnoses included, but were not limited to, hypertension, peripheral vascular disease, diabetes and malnutrition. The Quarterly Minimum Data Set (MDS) for Resident 17, dated 2/9/21, indicated the resident was independent with daily decision making. 2.) During an interview with Resident 31's family on 4/26/21 at 1:28 p.m., indicated the family had not been invited to a care plan meeting in a year. The family member had not had one in person or by phone conference. The family member would like to have one by phone or in person to have updates on the resident's health status. Review of the record of Resident 31 on 4/28/21 at 1:40 p.m., indicated the resident's diagnoses included, but were not limited to, Parkinson's disease, dementia with lewy body, dysphasia,	F 0657	**F657 Care Plan Timing and Revision** **Corrective action for the resident(s) found to have been affected by the deficient practice:** Resident 17 continues to reside in the facility. Resident 17 and their family has been offered a care plan meeting to ensure person centered care is being provided. Resident 31 continues to reside in the facility. Resident 31 and their family has been offered a care plan meeting to ensure person centered care is being provided. Resident C is a part of the complaint survey and is not identified on the Resident list provided to the facility Resident 79 continues to reside in the facility. Resident 79 and their family has been offered a care plan meeting to ensure person centered care is being provided. **Corrective action for the resident(s) found to have been affected by the deficient practice:** All residents have the potential to be affected by the deficient practice. SSD/designee has completed an audit of all residents residing in the facility to identify residents who are in need of a quarterly	06/02/2021

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	peripheral vascular disease, chronic kidney disease, osteoporosis, diabetes and chronic kidney disease. 3.) During an interview with Resident C on 4/27/21 at 12:24 p.m., indicated they had not been invited to a care plan meeting in person, virtually or by phone. Review of record of Resident C on 4/30/21 at 1:20 p.m., indicated the resident's diagnoses included, but were not limited to, Cerebral Vascular Accident (CVA), diabetes, dementia, major depressive disorder, hypertension, peripheral vascular disease and dysphasia. During an interview with the Director Of Nursing (DON) on 5/3/21 at 11:15 a.m., indicated she was unable to find documentation that Resident 17, Resident 31 and Resident 17 had care plan meetings. The DON indicated it would be the responsibility of Social Services to set up the care plan meetings with Residents and their family. During an interview with Social Services 2 on 5/3/21 at 11:30 a.m., indicated he was responsible to set up care plan meeting either by phone and in person. Social Services 2 indicated he was the only Social Services for the entire building at this time. During an interview with Social Services 2 on 5/3/21 at 1:01 p.m., indicated he was unable to find documentation for Resident 17, Resident 31 or Resident C of the last time a care plan meeting was held. The facility required a care plan meeting every three months. 4. The clinical record of Resident 79 was reviewed on 4-29-21 at 12:34 p.m. His diagnoses included, but were		care plan meeting. Residents and their families who have not had a care plan meeting in the last quarter will be invited to schedule a care plan to ensure person centered care is being provided. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Designee has reviewed “The Plan of Care” policy and procedure with the SSD regarding Quarterly Care Plan meetings to ensure person centered care. The Administrator/Director of Nursing/Designee held an in-service for nursing staff to provide education and expectations as it relates to the policy “Plan of Care Overview” regarding care plan meetings being completed quarterly to ensure person centered care. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/SSD/Designee will audit 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, then 1 resident a week for 4 weeks to ensure their Quarter Care Plan meeting has been scheduled to ensure person centered care. This will continue for no less than 3 months or compliance is maintained. The Director of Nursing will present the results of these audits	

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	not limited to, traumatic brain injury (TBI), alcoholic cirrhosis of liver, viral Hepatitis C and alcoholic polyneuropathy. His most recent Minimum Data Set (MDS) assessment, dated 3-25-21, indicated he was cognitively intact. In an interview with Resident 79 on 4-27-21 at 2:01 p.m., he indicated the last care plan meeting he could recall between he and the facility occurred in August of 2020. A review of his clinical record failed to identify any care plan meeting notes or information for a minimum of six months. In an interview with the Social Services Designee (SSD 2) on 5-3-21 at 10:08 a.m., he indicated in the last year, due to constraints with Covid-19, care plan meetings have been primarily conducted by phone. He recalled the facility had set up several planned care plan meetings with Resident 79, but the resident had failed to attend those meetings. He indicated he would have to locate the information regarding those meetings. In an interview with SSD 2 on 5-3-21 at 1:03 p.m., he indicated he could not find any records of care plan meetings for Resident 79. On 5-3-21 at 9:00 a.m., the Director of Nursing provided a copy of a policy entitled, "Plan of Care Overview," with a revision date of 7-26-18. This policy indicated, "It is the policy of this facility to provide resident-centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concern for our residents, staff and visitors. The purpose of this policy is to provide guidance to the facility to support the inclusion of the resident or resident representative in all		monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	aspects of person-centered care planning...General Care Planning (PoC) Goals and Guidelines: Residents/representatives will be informed of the PoC in the most understandable manner possible...The facility will...support and encourage resident/representative participation including, but not limited to, working cooperative [sic] to help residents/representatives to understand the comprehensive care planning process, hold meetings at a time when resident is functioning at his/her best, schedule meeting to accommodate a resident's representative that may include conference calls, video conference sessions or live sessions, plan adequate meeting time for decision making and discussion...Attendees will sign and date care plan meeting agendas/documents." 3.1-35(c)(2)(C) 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 interview and record review, the facility failed to assist a resident with showers (Resident 45), failed to assist a dependent resident with dentures and glasses (Resident C), and failed to provide a dependent resident with nail care and shaving (Resident 75). This affected 3 of 4 residents reviewed for Activities Of Daily Living (ADLs).	F 0677	**F677 ADL Care Provided for Dependent Residents** **Corrective action for the resident(s) found to have been affected by the deficient practice:** Resident #45 continues to reside at the facility Resident #45 has been assisted with showers per plan of care Resident C is a part of the	06/02/2021

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	Findings include: 1. Resident 45's record was reviewed on 4/29/21 at 10:57 a.m. The record indicated Resident 45 had diagnoses that included, but were not limited to, end stage renal disease, type 2 diabetes mellitus, anxiety, and depression. A Quarterly Minimum Data Set (MDS), dated 2/9/21, indicated Resident 45 was cognitively intact and required one person physical assistance with bathing, limited to transfer only, and extensive assistance of one for personal hygiene. An Annual MDS, dated 3/16/21, indicated Resident 45 was cognitively intact, and required one person physical assistance with personal hygiene and supervision with bathing. A care plan, last reviewed on 10/7/20, indicated a Focus for: "ADL (activities of daily living) Self Care Performance Deficit r/t (related to) Limited Mobility. Goal: [Resident 45] will maintain current level of function in (Bed Mobility, Transfers, Eating, Dressing, Toilet Use) through the review date. Interventions:...BATHING: Dependent on staff to provide a bath 2 x a week and as necessary. Prefers a day shift shower Tuesday, Thursday and Saturday...." On 4/29/21 at 12:39 p.m., Resident 45 indicated she sometimes did not get a shower. On 5/3/21 at 3:25 p.m., the Director of Nursing indicated she could only find 2 shower sheets for April that showed the resident had a shower. She provided the shower sheets and the documentation that the resident had a total of 5		complaint survey and is not identified on the Resident list provided to the facility Resident #75 continues to reside at the facility Resident #75 has been provided with nail care and shaving has been provided to resident #75 per plan of care. **Corrective action for the resident(s) found to have been affected by the deficient practice:** Resident's requiring assistance with showers, dentures, glasses, nail care and/or shaving have the potential to be affected by the deficient practice. An audit has been completed to determine residents requiring assistance with showers, dentures, glasses, nail care and/or shaving. Identified residents will be reviewed to ensure assistance is provided as per their plan of care. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Director of Nursing/Unit Manager/Designee held an in-service to provide education and expectations to nursing staff as it relates to the "Personal Bathing and Shower Policy" and "Nail and Hygiene Services" as it relates to providing resident centered care. **Corrective actions to be**	

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	showers in April 2021. 2.) During an observation on 4/26/21 at 11:43 a.m., Resident 31 was in her bed awake, the resident did not have dentures in place and did not have on glasses. The resident attempted to talk but was unable to understand what she was saying. During an interview with Resident 31's family on 4/26/21 at 1:40 p.m., indicated when the family came to visit the resident they had concerns because she did not have on her glasses and did not have her dentures in. The family indicated they use to be able to talk to the resident on her cell phone, but now they was unable to understand what she was saying. The family member contributed it to her Parkinson disease. During an observation on 4/28/21 at 11:19 a.m., Resident 31 was sitting in bed with no dentures in place and no glasses on. The resident attempted to communicate, but was unintelligible. During an observation on 4/29/21 at 2:21 p.m., Resident 31 was sitting in bed awake with no dentures in place and no glasses on. During an observation on 4/30/21 at 10:45 a.m., Resident 31 was sitting in bed awake with her dentures in place and no glasses on. Resident 31 was painting a picture, when told the picture was pretty the resident said "thank you, but I can not see". The resident's speech was very understandable. Interview with CNA 3 indicated she did not know why the resident did not have on her glasses. CNA 3 searched the resident's dresser for her glasses and was unable to locate them. Resident 31 indicated she had not seen her glasses "in awhile". CNA 3 indicated Resident 31 had not been wearing her dentures this week		**monitored to ensure the deficient practice will not recur:** The Director of Nurses/Unite Manager/Designee will audit 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, the 1 resident per week x 4 weeks to ensure showers, dentures, glasses, nail care and/or shaving have been provided per plan of care for resident centered care. This will continue for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	because they did not fit her well. When queried who this was reported to CNA 3 indicated Social Services 2. During an interview with Social Services 2 on 4/30/21 at 11:15 a.m., indicated no one had reported to him that Resident 31's dentures were not fitting properly. Social Services 2 indicated if that would have been reported to him he would of the resident in to see the dentist right away. During an interview and observation with LPN 1 and Social Service 2 on 4/30/21 at 11:25 a.m., Resident 31 was sitting in her bed painting. LPN 1 asked the resident if her dentures were fitting ok and the resident said "yes" LPN 1 asked the resident if the dentures were causing her pain and the resident said "no". LPN 1 agreed the resident's dentures were observed to fit and the resident's speech was understandable. Review of the record of Resident 31 on 4/28/21 at 1:40 p.m., indicated the resident's diagnoses included, but were not limited to, Parkinson's disease, dementia with lewy body, dysphasia, peripheral vascular disease, chronic kidney disease, osteoporosis, diabetes and chronic kidney disease. The Quarterly Minimum Data Set (MDS) for Resident 31, dated 3/9/21, indicated the resident's ability to see with glasses was adequate, the resident was independent with daily decision making and required extensive assistance of one person for personal hygiene. During an interview with Social Service 2 on 5/3/21 at 1:01 p.m., indicated Resident 31's glasses could not be located. No one had reported to him that the resident's glasses were			

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missing until it was reported to him on 4/30/21 by the surveyor.

3.) During an interview with Resident C's family member on 4/27/21 at 12:27 p.m., indicated the facility did not keep Resident C and they felt like he looked dirty. The family member indicated the resident preferred to be shaven daily and the resident was not shaved for 3-4 days at a time. The resident would at times have a full beard and mustache when she visited.

During an observation on 4/27/21 at 12:42 p.m., Resident C was in bed his nails were long jagged with black substance underneath them. The resident had a moderate amount of facial and neck hair.

During an observation on 4/28/21 at 11:00 a.m., Resident C was in bed, his nails were long, jagged with black substance. The resident had a moderate amount of facial and neck hair.

During an observation on 4/29/21 AT 10:20 a.m., Resident C was in bed, his nails were long, jagged with black substance. The resident had a moderate amount of facial and neck hair.

During an interview and observation on 4/30/21 at 11:00 a.m., Resident C was in bed facial and neck hair remained, his nails were long with black substance underneath them. The resident's family member was in the room visiting the resident. The family member picked up the resident's hands and stated "his nails were long and dirty" and also indicated he always liked to be shaved daily and when she visited him he often had facial and neck hair.

Review of record of Resident C on 4/30/21 at

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	1:20 p.m., indicated the resident's diagnoses included, but were not limited to, Cerebral Vascular Accident (CVA), diabetes, dementia, major depressive disorder, hypertension, peripheral vascular disease and dysphasia. The Quarterly Minimum Data Set (MDS) for Resident C, dated 4/8/21, indicated the resident was severely impaired for daily decision making and rarely/never made decisions. The resident required extensive assistance of one person for personal hygiene. The plan of care for Resident C, dated 10/7/20, indicated the resident had Activities Of Daily Living (ADL) deficit related to dementia and weakness. The interventions included, but were not limited to, honor the resident's preferences whenever possible and nail care twice a week. During an interview with the Director Of Nursing (DON) on 5/3/21 at 1:49 p.m., indicated it was the responsibility of the CNA's do do nail care for residents without diabetes and activity staff also was able to provide nail care for residents. The DON indicated it was the CNA's and Nurses responsibility to ensure residents were assisted with shaving. The personal bathing and shower policy provided by the DON on 5/3/21 at 9:00 a.m., indicated the facility would provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. "Residents have the right to choose their schedules, consistent with their interests, assessments, and care plans including choice for personal hygiene. Oral care and denture cleaning would be provided. "Men should be shaved during bathing process.			

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	3.1-38(a)(3)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.			
	Based on observation, interview and record review the facility failed to provide self-initiated and group activities for a dependent resident for 1 of 2 residents reviewed for activities (Resident 31). Finding include: During an observation on 4/26/21 at 11:38 a.m., Resident 31 was in bed awake. The resident had no radio or TV on. The resident's TV cable connection plug was unplugged and laying on top of the TV. The resident had no independent activities available. During an interview with Resident 31's family on 4/26/21 at 1:23 p.m., indicated the resident liked to watch TV, coloring and playing cards. During an observation on 4/28/21 at 11:19 a.m., Resident 31 was sitting up in bed with no TV or radio and no independent activities available.	F 0679	**F679 Activities Meet Interest /Needs Each Resident** **Corrective action for the resident(s) found to have been affected by the deficient practice:** Resident #31 continues to resident at the facility The Activity Director has interviewed resident and the resident's family regarding preferences for self-initiated and group activities. The care plan for Resident #31 has been updated to reflect identified preferences. **Corrective action for the resident(s) found to have been affected by the deficient practice:** All dependent residents have the potential to be affected by the	06/02/2021

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	During an observation on 4/28/21 at 1:51 p.m., Resident 31 was sitting up in bed with no TV or radio and no independent activities available. During an observation on 4/29/21 at 2:21 p.m., Resident 31 was sitting up in bed with no TV or radio and no independent activities available. During an observation on 4/30/21 at 10:45 a.m., Resident 31 was sitting in bed awake with no glasses on. Resident 31 was painting a picture, when told the picture was pretty the resident said "thank you, but I can not see". Review of the record of Resident 31 on 4/28/21 at 1:40 p.m., indicated the resident's diagnoses included, but were not limited to, Parkinson's disease, dementia with lewy body, dysphasia, peripheral vascular disease, chronic kidney disease, osteoporosis, diabetes and chronic kidney disease. The Annual Minimum Data Set (MDS) for Resident 31, dated 6/11/20, indicated it was very important to the resident to have books, newspapers available, keep up with the news, do things in groups of people, go outside, go to church and to do her favorite activity. The Quarterly MDS for Resident 31, dated 3/9/21, indicated the resident required extensive assistance of two people for transfers and used a wheelchair for mobility. The activity care plan for Resident 31, dated 10/7/21, indicated the resident attends activities of interest/choice and engages in self-initiated leisure activities. The resident liked to cook/bake in activities. Enjoys word puzzles and coloring in		deficient practice. The Activity Director will interview obtain resident preference for self-initiated and group activities for dependent residents through interviews with the resident or their families. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Activity Director/Designee held an in-service to provide education and expectations to facility staff as it relates to the "Activity Program Policy" and providing self-initiated and group activities for dependent residents. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Activity Director/Designee will audit 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, the 1 resident per week x 4 weeks to ensure self-initiated and group activities for dependent residents are being provided per their preference. This will continue for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will	

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	room, Invite, encourage and assist as needed to activities of choice. interest as tolerated by the resident. Likes bingo, outings and reading, provide Daily Chronicle, coloring, word searches and other puzzles for independent activities. Respect wishes to decline invitations when rest/leisure-type activities are preferred. The resident enjoys playing bingo, cards and other games. Review of the activity participation for Resident 31, dated April 2021, indicated the resident received "1:1/conversation/social time/family visit" on 4/2/21 at 1:34 p.m., 4/6/21 at 1:59, 4/9/21 at 1:00 p.m., 4/13/21 at 1:59 p.m., 4/16/21 at 1:59 p.m., 4/21/21 at 1:59 p.m., and 4/27/21 at 9:40 a.m. The resident had a "beverage/snack cart/socials" on 4/9/21 at 1:40 p.m., and "mail/reading/talk book/writing" on 4/1/21 at 1:59 p.m. The activity participation documentation did not indicate how long the resident was engaged or the resident's response to the activity . During an interview with the Activity Director on 5/3/21 at 11:40 a.m., indicated the Activity staff and the CNA's were responsible to ensure Resident 31 had self-initiated activities available and set up for her in her room. The Activity Director indicated it was the responsibility of the CNA's to assist Resident 31 to group activities. The Activity Director indicated the facility did not enough activity staff. The Activity Program policy provided by the Director Of Nursing (DON) on 5/3/21 at 9:00 a.m., indicated the facility would provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of		have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	the residents. The activity program was designed to encourage restoration to self-care and maintenance of normal activity that is geared to the individual needs. 3.1-33(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, interview and record review, the facility failed to ensure a safe environment for a resident dependent on staff for bathing and resulted in a resident falling in the shower room (Resident D) and failed to investigate and determine a root cause analysis, conduct neurological checks and implement interventions post fall (Resident C) for 2 of 5 residents reviewed for accidents. Findings include: 1. The clinical record for Resident D was reviewed on 5/3/21 at 10:53 a.m. The diagnoses included, but were not limited to, dysphagia, cerebral infarction, insomnia, bipolar disorder, anxiety disorder and major depressive disorder. An admission Minimum Data Set (MDS)	F 0689	**F689 Free of Accident Hazards/Supervision/Devices** **Corrective action for the resident(s) found to have been affected by the deficient practice:** Resident D is a part of the complaint survey and is not identified on the Resident list provided to the facility Resident C is a part of the complaint survey and is not identified on the Resident list provided to the facility **Corrective action for the resident(s) found to have been affected by the deficient practice:** All residents requiring assistance with bathing have the potential to	06/02/2021

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	assessment, dated 12/9/20, noted Resident D with severe cognitive impairment and independent with setup assistance with bathing and personal hygiene. Resident D utilized a cane. A quarterly MDS assessment, dated 3/10/21, noted limited assistance with one staff person for bed mobility and ambulation. The need for extensive assistance with one staff person for transfers and supervision with one staff person for hygiene. Bathing activity didn't occur during the assessment. A care plan for activities of daily living, revised 4/27/21, indicated Resident D required weight bearing assistance of one staff person with bathing and transfers. A care plan for falls, revised 4/30/21, indicated Resident D to have supervision during showers initiated on 3/16/21. A progress note, dated 3/15/21 at 11:00 p.m., indicated the following, "...Called into shower room by CNA [certified nursing assistant]. Resident sitting on shower room floor on buttocks...Resident states he fell on buttocks while trying to reach for his pants...." A document titled "Post Fall Evaluation", dated 3/15/21, indicated Resident D had an unwitnessed fall in the shower room to where the floor was wet, and resident was barefoot. Resident reported he was reaching for his pants and fell onto his buttocks. The document was signed by Licensed Practical Nurse (LPN) 5. A progress note titled "IDT [interdisciplinary team] Follow Up", dated 3/16/21, indicated Resident D lost balance and an intervention for		be affected by the deficient practice. An audit has been completed for residents requiring assistance with bathing and have had a fall in the last 30 day look back. These residents were audit for assistance per plan of care provided, investigation completed to determine root cause, neurological checks and interventions implemented post fall. Any identified concerns were addressed as appropriate. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Director of Nursing/Unit Manager/Designee held an in-service to provide education and expectations to nursing staff as it relates to the "Occurrence Incident Reporting" policy as it relates to providing resident centered care needs per plan of care. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nurses/Unite Manager/Designee will audit 5 resident per week x 4 weeks, then 3 resident per week x 4 weeks, the 1 resident per week x 4 weeks to ensure resident receives assistance per plan of care to meet resident centered care needs. Any identified concerns will be immediately addressed.	

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	resident to have standby assist with showers was put into place. Resident D had previous documentation for the need for staff assistance with bathing on the activities of daily living care plan, revised 4/27/21. An interview conducted with Resident D, on 4/26/21 at 2:05 p.m., indicated he fell in the shower room recently and now he must ask staff members for a shower. An interview conducted with LPN 5, on 4/29/21 at 2:24 p.m., indicated during shift change, on 3/15/21, Resident D was asking for a shower. Resident D was pretty independent but he does like to stand up in the shower so the nursing staff will lay towels down for him. The nursing staff found Resident D on the floor after the call light was on. An interview conducted with Unit Manager 6, on 4/29/21 at 3:33 p.m., indicated she believes Resident D went into the shower room by himself. The nursing staff were caring for another resident. The shower door is locked, and Resident D has the code to the shower room. Resident D likes to stand in the shower besides sitting in the shower chair. The staff would usually put towels down for traction and the potential for slippery floors. An interview with Resident D, on 4/29/21 at 3:55 p.m., indicated he doesn't recall the circumstances of the fall incident, but he does know the code to the shower room. He was unsure who told him the code to the shower room.		This will continue for no less than 3 months and compliance is maintained. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	An observation conducted on 4/30/21 at 2:25 p.m., with CNA 7, noted 2 shower rooms on Rosewood. One, towards the left, was locked with the green button to access the room. The second shower room, on the right, was smaller but locked with the need for a numerical code to gain entry. An interview conducted with the Director of Nursing (DON), on 5/3/21 at 2:50 p.m., indicated she would not give the residents a code into the shower room. Resident D was found in the shower room towards the right side that is locked. 2.) During an interview with Resident C's family on 4/27/21 at 12:29 p.m., indicated the resident had a fall out of bed a couple months ago. The family member indicated there had been a mat beside his bed, but it had not been there for awhile. During an observation on 4/28/21 at 11:00 a.m., Resident C was in bed on his left side. There were no fall interventions observed. During an observation on 4/29/21 at 10:20 a.m., Resident C was in bed on his left side. There were no fall interventions observed. During an observation on 4/30/21 at 2:15 p.m., Resident C was in bed positioned poorly near the edge of the bed. Reported to the Director Of Nursing (DON) and she repositioned the resident to the middle of his bed. Review of record of Resident C on 4/30/21 at 1:20 p.m., indicated the resident's diagnoses included, but were not limited to, Cerebral Vascular Accident (CVA), diabetes, dementia, major depressive disorder, hypertension,			

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	peripheral vascular disease and dysphasia. The Quarterly Minimum Data Set (MDS) for Resident C, dated 4/8/21, indicated the resident was severely impaired for daily decision making and rarely/never made decisions. The resident required extensive assistance of two people for bed mobility, extensive assistance of one person to transfer, did not ambulate and used a wheelchair for a mobility device. The fall care plan for Resident C, dated 10/7/21, indicated the resident was at risk for falls due to the fall risk assessment. There no interventions implemented after 10/7/21 and no interventions addressing the resident falling out of bed. The nurses note for Resident C, dated 1/10/21 at 4:06 p.m., indicated the resident rolled out of bed. "The resident states he was trying to get to bed when he rolled out of bed." The resident landed on his right elbow and acquired a small skin tear, a dressing was placed on the skin tear. The resident denied neck or back pain. Neurological assessment started. The family and physician was notified. During an interview with the DON on 5/3/21 at 11:15 a.m., indicated she was not able to locate a fall investigation to determine the root cause of Resident C's fall on 1/10/21, unable to find neurological checks for the resident after the fall and was unable to find that an intervention was implemented after the fall on 1/10/21. The DON indicated the nurse should have implemented a fall intervention immediately after the fall, then the Interdisciplinary Team (IDT) would have reviewed the fall the next business day and determine the root cause of the fall and review the fall intervention implemented was			

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	appropriate and adequate. The "Occurrence Incident Reporting" policy provided by the Executive Director on 5/3/321 at 1:45 p.m., indicated the facility was to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. "Safety is a primary concern for our residents". During an interview with the Executive Director on 5/3/21 at 2:05 p.m., indicated the facility did not have a specific policy for falls. This Federal tag relates to Complaint IN00348394. 3.1-45(a)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to implement non-pharmacological interventions for pain as ordered and follow-up with a scheduled physician order for gabapentin for 1 of 2 residents reviewed for pain management. (Resident 30) Findings include: 1a. The clinical record for Resident 30 was	F 0697	**F679 Activities Meet Interest /Needs Each Resident** **Corrective action for the resident(s) found to have been affected by the deficient practice:** Resident #31 continues to resident at the facility The Activity Director has interviewed resident and the resident's family regarding	06/02/2021

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	reviewed on 4/29/21 at 12:52 p.m. The diagnoses included, but were not limited to, cerebral infarction, anxiety disorder, major depressive disorder and headache syndrome. An admission Minimum Data Set (MDS) assessment, dated 12/9/20, noted Resident D with severe cognitive impairment and limitation to one side of upper extremities. A care plan for pain, dated 12/7/20, indicated the following, "...[Name of Resident 30] has chronic pain r/t [related to] migraine headaches and CVA [cerebrovascular accident]...Interventions...Administer non-pharmacological interventions [repositioning, diversion activities, snacks and fluids, ice / heat, music therapy, relaxation techniques, imagery]...Pain management consult...Provide medication per orders...." A physician order, dated 12/4/20, indicated the use of Tylenol 325 milligrams and give 2 tablets every 6 hours as needed for pain. A physician order, dated 12/30/20, indicated the use of Aspercreme Lidocaine Patch 4% and apply to left shoulder topically every 12 hours as needed for left shoulder pain. A physician order, dated 1/27/21, indicated the use of scheduled ibuprofen 800 milligram tablet every 6 hours for left shoulder pain. A physician order, dated 1/28/21, indicated the following, "...apply heating pad from therapy dept [department] as tolerated to L [left] shoulder for pain every 6 hours as needed...." A "Pain Observation Tool", dated 4/21/21,		preferences for self-initiated and group activities. The care plan for Resident #31 has been updated to reflect identified preferences. **Corrective action for the resident(s) found to have been affected by the deficient practice:** All dependent residents have the potential to be affected by the deficient practice. The Activity Director will interview obtain resident preference for self-initiated and group activities for dependent residents through interviews with the resident or their families. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Activity Director/Designee held an in-service to provide education and expectations to facility staff as it relates to the "Activity Program Policy" and providing self-initiated and group activities for dependent residents. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Activity Director/Designee will audit 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, the 1 resident per week x 4 weeks to ensure self-initiated and group activities for dependent residents are being provided per	

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	indicated an acceptable pain level of 3 out of 10 with the use of scheduled medication and as needed medication was marked as "no". An interview conducted with Resident 30, on 4/26/21 at 2:05 p.m., indicated he had pain to his left arm/shoulder area rated at an 8 out of 10 on the pain scale. Resident 30's pain level summary was reviewed and noted a pain level greater than 3 on the following date(s)/time(s): 4/28/21 at 12:44 p.m., 4/21/21 at 5:22 p.m., 4/7/21 at 8:49 a.m., 3/22/21 at 5:38 a.m., 3/22/21 at 2:11 a.m., 3/17/21 at 5:14 p.m., 3/17/21 at 12:15 a.m. & 3/16/21 at 1:10 p.m. An interview conducted with Resident 30, on 4/29/21 at 10:17 a.m., indicated his left shoulder hurts very bad and rated his pain 8 out of 10. He stated the nursing staff were supposed to give him a heating pad for his shoulder pain, but he hasn't seen it. He commented "I need some relief. I feel like I am going to cry". An interview conducted with Licensed Practical Nurse (LPN) 8, on 4/29/21 at 12:25 p.m., indicated Resident 30 receives scheduled ibuprofen every 6 hours. She wasn't aware of any orders present for the application of a heating pad for Resident 30. An interview conducted with Certified Nursing Assistant (CNA) 7, on 4/30/21 at 2:22 p.m., indicated she wasn't aware of Resident 30 having		their preference. This will continue for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	a heating pad and she had never seen one in his room. 1b. A Nurse Practitioner (NP) note, dated 3/4/21, indicated the following, "...Pain/Manic...Nursing requested pt [patient] to be seen do to [sic] pacing the halls with several complaints. Pt [patient] presents manic with a flight of ideas. Concerns include we needed to surgically rebreak his left arm for it to heal properly, he has burning pain legs [sic]...Plan...Pain: Start gabapentin trail for 10 days 200mg [milligrams] TID [three times daily] routine 1000 mg QD [daily] ER [extended release]...." A Nurse Practitioner (NP) note, dated 3/4/21 at 10:04 a.m., indicated the following, "...pt [patient] with s/s [signs and symptoms] of mania yesterday...Pt [Patient] admits to feeling irritable...Pt stating not sleeping well stating d/t [due to] pain on side...Elder approached the nurses station and asked about seeing someone for his shoulder...." A physician order, dated 3/3/21, indicated the following, "...gabapentin tablet...give 200 mg [milligrams] by mouth three times daily for left arm pain for 10 days...." The electronic medication administration record (EMAR), dated March of 2021, indicated the gabapentin 200 milligram order was given as ordered. There was no order for gabapentin 1,000 milligrams extended release to be administered for Resident 30. The clinical record did not indicate any contraindications or reasoning for not initiating the order for gabapentin 1,000 milligrams			

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	extended release daily. An interview conducted with the Director of Nursing (DON), on 5/3/21 at 2:50 p.m., indicated she would look into the gabapentin order to see if it was changed to not give the routine 1,000 milligram extended-release dose. The order for a heating pad was an old order from therapy but she spoke with the Unit Manager and she indicated Resident 30 hasn't had shoulder pain for a while. A policy titled "Pain Management and Assessment", dated 7/25/18, was provided by the DON on 5/3/21 at 12:35 p.m. The policy indicated the following, "...b. Additionally, the basis for the pain management includes but is not limited to...i. Resident's needs and goals...ii. Source, type, and intensity of pain...iii. To the extent possible, the interdisciplinary team educates the resident and/or representative about the need to report pain when it occurs and about the various approaches to pain management and the need to monitor the effectiveness of the interventions used...d. History of pain and treatment for the resident...i. To include non-pharmacological and pharmacological treatment and whether or not each treatment has been effective...VI. Documentation...a. Medication pain relief and response...b. Non-pharmacologic measures attempted and the resident response...c. Care plan updates as needed...." 3.1-37(a)			
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			

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	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 interview and record review, the facility failed to ensure a minimum of one Registered Nurse (RN) direct care coverage in the facility for eight consecutive hours during 3 of 8 days of the survey which ended on 5-3-21. Findings included: On 5-3-21 at 12:27 p.m., the Director of Nursing (DON) provided updated copies of the "Posting of Licensed and Unlicensed Direct Care Staff," for the time period of 4-26-21 through 5-3-21. These documents indicated on 3 of 8 dates, specifically 4-27-21, 4-28-21 and 5-1-21, there was not any RN direct care coverage identified. Additionally, review of the facility's "as worked" schedules for the facility was congruent with this information for the same dates. In an interview with the Executive Director on 5-3-21 at 1:45 p.m., he indicated the facility does not have a specific policy related to RN coverage, but merely follows the State and Federal regulations related to this topic.	F 0727	**F727 RN 8 hours/7days/Wk.** **Full Time DON** **Corrective action for the resident(s) found to have been affected by the deficient practice:** The Facility has maintained RN coverage 8 hours/7days/week. **Corrective action for the resident(s) found to have been affected by the deficient practice:** All residents have the potential to be affected by the deficient practice A 30 day look back of RN coverage has been completed to identify the areas of opportunity in maintaining RN coverage 8 hour/7days/wk. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of	06/02/2021

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	3.1-17(b)(3)		Nursing/Designee provided an in-service with the Scheduling Coordinator regarding State and Federal regulations regarding RN Coverage 8 hours/7days/week. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/Scheduling Coordinator/Designee will audit staffing for 5 days per week x 4 weeks, then 3 days per week x 4 weeks, then 1 day a week x 4 weeks to ensure RN coverage is in place 8 hours day. This will continue for no less than 3 months and compliance maintained. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;			
	Based on observation, interview and record review, the facility failed to ensure medication error rates were <5% by crushing and/or opening extended-release medication that resulted in a	F 0759	**F759 Free of Medication Error Rates 5 Percent of More** **Corrective action for the resident(s) found to have been affected by the deficient**	06/02/2021

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	medication error rate of 6.25%. (Resident 49 and Resident 2) Findings include: 1a. A medication administration observation was conducted with Licensed Practical Nurse (LPN) 9 on 4/28/21 at 8:28 a.m. LPN 9 prepared the following medications for Resident 49: Lasix 20 milligrams (2 tablets), Lexapro 5 milligrams, metoprolol 25 milligrams extended-release tablet & glipizide 5 milligrams (half tablet). All of the medications were placed in a packet and crushed by LPN 9. The medications were mixed with applesauce and administered to Resident 49. A physician order, dated 9/9/20, indicated metoprolol succinate 25 milligrams extended-release tablet was to be administered daily for Resident 49. 1b. A medication administration observation was conducted with LPN 9 on 4/28/21 at 8:50 a.m. LPN 9 prepared the following medications for Resident 2: clopidogrel bisulfate 75 milligrams, fluoxetine 60 milligrams, metformin 500 milligrams, tamsulosin capsule 0.4 milligrams & Ritalin 10 milligrams. LPN proceeded to place the clopidogrel bisulfate, fluoxetine, metformin and Ritalin into a packet and crush the medication. She opened		**practice:** Resident #49 continues to reside at the facility A medication review for resident #49 has been completed and medication orders obtained for those medications that were crushed and/or opened inappropriately for medication administration. Resident #2 continues to reside at the facility A medication review for resident #2 has been completed and medication orders obtained for those medications that were crushed and/or opened inappropriately for medication administration. **Corrective action for the resident(s) found to have been affected by the deficient practice:** Residents requiring medications to be crushed have the potential to be affected by the deficient practice. An audit has been completed to determine those residents requiring medications to be crushed for administration. Further, those residents requiring medications to be crushed have been reviewed to ensure all medications are appropriate to be crushed for administration. **Measures/systemic changes put into place to ensure the deficient practice does not recur:**	

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	the capsule of tamsulosin 0.4 milligrams and placed the powder substance of medication into the applesauce of Resident 2's other medications for administration to Resident 2. A physician order, dated 4/8/20, indicated tamsulosin capsule 0.4 milligrams capsule was to be administered daily for Resident 2. A document titled "Medications Not To Be Crushed", revised 10/2018, was provided by Unit Manager 6 on 4/30/21 at 10:52 a.m. The document indicated the following medications listed as to not be crushed: metoprolol extended-release tablet due to it being a timed-release formation & tamsulosin capsule due to it being a timed-release formation. An interview conducted with the Director of Nursing (DON), on 5/3/21 at 2:50 p.m., indicated medications should not be crushed if they are extended release. A policy titled "Medication Administration", revised 12/14/17, was provided by the DON on 4/29/21 at 1:30 p.m. The policy indicated the following, ""...t. Crushing medications...iii. Follow manufacturer's recommendations for medications that note "do not crush"...."" 3.1-48(c)(1)		The Director of Nursing/Unit Manager/Designee provided an in-service to provide education and expectation as it relates to the “Medication Administration” Policy regarding following manufacturer guidelines for medications appropriate to crush for administration. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Director of Nursing/Unit Manager/Designee will complete a Medication Observation 5 days a week on varying shifts, then 3 days per week on varying shifts x 4 weeks, then 1 day a week x 4 weeks to ensure medications are appropriate to be crushed and the medication error is less than 5%. This will continue for no less than 3 months and compliance is maintained. Any identified concerns will be immediately addressed. The Director of Nursing will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control			

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	The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,			

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	depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to prevent and/or contain the spread of COVID-19 by failure to wear personal protective equipment (PPE) upon entrance into a room on transmission-based precautions (TBP) and having a resident on TBP out in a common area around other residents. This had the potential to affect 11 of 103 residents that reside in the facility.	F 0880	**F 880** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** The residents identified are confidential related to complaint investigation. **Identification of other residents having the potential to be**	05/29/2021

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	Findings include: 1. An observation was conducted on 4/26/21 at 12:12 p.m. of the Reflections 1 dining room. Resident 57 was sitting at a table by himself in the dining room with his mask pulled down while eating. There were 10 other residents consuming lunch in the dining room during that time. Resident 57 proceeded to finish eating and go back into his room that was identified as a "yellow" room on TBP. Certified Nursing Assistant (CNA) 10 was interviewed during the observation and she indicated Resident 57 came into the dining room and she was aware he was on TBP and that's why he was at a table by himself. CNA 10 commented "I wasn't thinking", in regard to letting Resident 57 consume lunch in the dining room around other residents while on TBP. An interview conducted with Unit Manager 6 on 4/27/21 at 10:30 a.m., indicated Resident 57 is not fully vaccinated and is a readmission from a hospital. Resident 57's clinical record was reviewed on 5/3/21 at 12:58 p.m. He was readmitted to the facility from the hospital on 4/14/21. A physician order was noted for droplet precautions from 4/14/21 to 4/28/21. 2. An observation of the Brookshire Unit was conducted on 4/27/21 at 2:05 p.m. CNA 11 was observed going into Resident 202's room that was noted as "yellow" on TBP. She was not wearing a gown, eye protection, KN95 and/or an N95 mask upon entry into Resident 202's room. Upon interview with CNA 11, she indicated she was wearing all personal protective equipment upon entry into Resident 202's room. She was		**affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice. The DON or designee will complete the following: Ensure the resident/residents affected/potential affected has been isolated in Transmission Based Precautions according to CDC and IP recommendations and ensure care giving staff are educated on isolation procedures. Ensure all staff are aware of who is on isolation and appropriate signage implemented. Ensure staff involved are educated on how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection. Follow CDC and facility policy. Policy: USE OF PPE WHILE IN THE FACIITY and Criteria for Covid 19 Isolation Indiana Department of Health: Covid 19 LTC Facility Infection Control Standard Operating Procedures CDC: PPE sequence Competency: AAPACN Personal-Protective-Equipment-PPE-Donning-and-Doffing	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not able to comment on why Resident 202 was on TBP. Resident 202's clinical record was reviewed on 5/3/21 at 1:05 p.m. He was admitted to the facility on 4/14/21 and was not fully vaccinated. A physician order, dated from 4/15/21 to 4/29/21, indicated the following, "...Place resident in droplet precautions...." An interview conducted with the Director of Nursing (DON), on 5/3/21 at 2:50 p.m., indicated the expectations are to follow the CDC (Centers for Disease Control) and the State guidelines for TBP and PPE use. A policy titled "Use of PPE while in the facility", updated 4/12/21, was provided by the DON on 5/3/21 at 3:10 p.m. The policy indicated the following, ""...New Admissions/Re-admissions who are not fully vaccinated against Covid-19, Residents Who Have Been Exposed [Yellow Quarantined/Observation Area] Residents with S&S [signs and symptoms] of COVID, but does not have a positive or waiting on results of their test: These are residents who "may" be contagious...N95 mask and eye protection required on the general area of the unit...Full PPE consisting of N95 mask, eye protection, gown, and gloves are donned when entering resident room...."" A document titled "COVID-19 LTC [long term care] Facility Infection Control Guidance Standard Operating Procedure", revised 4/7/21, indicated the following, "...MASKS AND EYE PROTECTION...N95 [or approved KN95] masks should be worn in COVID units and with any resident who is symptomatic or awaiting testing in transmission-based precautions [red or yellow		**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** A Root Cause Analysis (RCA) was conducted with the Infection Preventionist (IP) and input from the IDT and the facility Medical Director/IP/DON. The root cause was identified resulting in the facility's failure. Solutions were developed and systemic changes were identified that need to be taken to address the root cause. The Infection Preventionist and IDT reviewed the LTC infection control self-assessment and identified changes to make accurate **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** After the IDT and Infection Preventionist completed the RCA and LTC infection control assessment, training identified above was implemented to facility staff. The training will be conducted by the DON, IP or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155188	A. BUILDING 00 B. WING	05/03/2021

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	zone]...GENERAL COVID-19 INFECTION CONTROL FOR LONG-TERM CARE FACILITIES...Unknown COVID-19 status [Yellow]: All residents in this category warrant transmission based precautions [droplet and contact]. HCP [healthcare personnel] will wear single gown per resident, glove, N95 mask and eye protection [face shield/or goggles]. Gowns and gloves should be changed after every resident encounter with hand hygiene performed...." 3.1-18(a)		Medical Director with documentation of completion. To ensure Infection Control Practices are maintained, the following monitoring will be implemented. 1. The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA and as noted above, daily or more often as necessary for 6 weeks and until compliance is maintained. ensure staff don appropriate PPE upon entrance to a resident's room ensure residents on transmission based precautions are not out in the common areas with other residents 2. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified in B1 as above. This will occur for 6 weeks and until compliance is maintained. Infection Control Practices ensure staff don appropriate PPE upon entrance to a resident's room	

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			ensure residents on transmission based precautions are not out in the common areas with other residents **Quality Assurance and Performance Improvement (QAPI):** The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	