STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. BUILDING 00 B. WING	06/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

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F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on April 13, 2022. This visit included a PSR to the Investigation of Complaint IN00376905 completed on April 13, 2022. This visit was in conjunction with a PSR to the Investigation of Complaint IN00374274 completed on March 2, 2022. Complaint IN00376905 - Corrected. Complaint IN00374274 - Corrected. Unrelated deficienies are cited. Survey dates: June 1, 2, 3, 6, and 7, 2022. Facility number: 000376 Provider number: 155717 AIM number: 100275510 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 4 Medicaid: 32 Other: 13 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 17, 2022.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by Federal and State law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during survey event ID V9S711. Please accept this plan of correction as the provider's credible allegation of compliance We respectfully request a desk review for compliance.	

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

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F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview, and record review, the facility failed to ensure 2 of 7 residents were free of physical abuse from CNA 23. (Resident 29 and Resident 53). The deficient practice resulted in Resident 29 experiencing a soft tissue injury to the left wrist with increased pain. The facility failed to ensure 3 of 7 residents were free of verbal abuse by CNA 23. (Resident 26, Resident 25, and Resident 30). The deficient practice resulted in 5 of 7 residents overhearing the abuse and experiencing negative reactions or outcomes (Resident 29, Resident 39, Resident 53, Resident 9, and Resident 30). Findings include: 1. On 6/1/22 at 10:00 a.m., Resident 39 was interviewed. He indicated Resident 29 was hurt by Certified Nursing Assistant (CNA) 23. CNA 23 left marks all over his arm, and when his girlfriend came in to visit, she "raised hell over it." CNA 23	F 0600	F 0600 – Free From Abuse and Neglect It is the practice of this facility to ensure that residents are free from abuse and neglect. All residents have the potential to be effected; however, no harm came to any. CNA 23 was terminated. Administrator and DON/designee attended Resident Council on June 22 and talked to them in regards to Resident Rights and Abuse, who to report abuse to and assured them that there would be no retaliation against them for reporting and the posting of contact numbers for ombudsman. All interview able residents were interviewed and asked to verify their answers by signing the paper. Skin assessments were	07/06/2022

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	was suspended then too, but they let him come back to work. On 6/1/22 at 10:40 a.m., Resident 29 was observed sitting up in his wheelchair beside his bed. At this time, he indicated his wrist hurt. His left wrist was observed resting across his lap. The wrist area was swollen and when Resident 29 lightly pressed it with his other hand he indicated it was tender to touch. Resident 29 indicated Certified Nursing Assistant (CNA) 23 had been "too rough" with him during a transfer a couple weeks ago when he "yanked him up" out of his wheelchair which caused his wrist to swell up and start hurting. Resident 29 indicated he usually had pain on his left side because that was the side which was "taken out" during his stroke, but the pain in his wrist was new and had not gone away since the incident with CNA 23. Resident 29 indicated he used to think CNA 23 was a "pretty good worker", even if he was always in a hurry and sometimes "made you feel like a pest." After Resident 29 complained about the pain in his wrist and what happened, "everyone was really serious for the first few days, they got me an x-ray, and ice packs," but when the x-ray came back, they said it was fine and the pain was from his arthritis, so they let CNA 23 come back and everything went back to normal including CNA 23 caring for Resident 29. During a confidential interview, it was indicated CNA 23 was a "serial abuser." They heard about the alleged incidents upon return to work, that CNA 23 had hurt Resident 29's arm and yelled at Resident 26. Also, CNA 23 yelled at Resident 25 all the time, but when that was "investigated" previously, and he was suspended and came back to work anyway. As for Resident 29, he knew exactly what happened to him. "Everyone" tried to		completed on all other residents, with no concerns noted. Staff were interviewed and signed the paper verifying their answers. Staff was educated about abuse by the DON or designee on June 28, 2002. Administrator or Social Services will inter 5 resident and staff members weekly x 4 weeks; then 4 resident and staff members weekly x 4 weeks; then 3 resident and staff members x 4 weeks; then 2 residents and staff member x 4 weeks; then 1 resident and staff member weekly x 4 weeks; then 1 resident and staff member monthly x 2 months. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved. July 1, 2022 Ms. Brenda Buroker: Please find this correspondence as my official IDR to F600, CFR 483.12(a)(1) on the survey at Alpha Home with the exit date of April 13, 2022. I wish to formally challenge the severity of G on said tag on the basis that no actual	

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	say, "he's making it up for attention," but that was simply not true. Yes, he would get fixated on certain things and had a distracted attention span because of his stroke, but he was telling the truth. Staff upon hire were told if you were suspended over allegations of abuse that was that and you would be fired. But not since CNA 23 had been suspended 3 or 4 times over abuse allegations. During an interview on 6/1/22 at 3:05 p.m., Licensed Practical Nurse (LPN) 19 indicated he was the nurse on shift when the concern with Resident 29's wrist was brought to his attention. Resident 29's girlfriend had been in to visit and came to him with the concern. He went to look at Resident 29's wrist and found it to be swollen, and the Resident complained of "great pain" when it was touched or tried to move. Resident 29 had constant pain on that side anyway, so staff had to be extra careful and gentle when moving his affected side. On 6/1/22 at 10:50 a.m., Resident 29's medical record was reviewed. He had admitted to the facility on 2/7/22 with active and current diagnoses which included, but were not limited to, hemiplegia and hemiparesis (paralysis and muscle weakness) following cerebral infarction (stroke), muscle wasting and atrophy, and abnormal posture. Nursing Progress Note, dated 2/14/22 at 10:00 a.m., indicated a telehealth video visit was conducted for his recent admission, medication refill, and covid screening. " ... He takes Percocet 7.5/325mg for chronic bilateral LE pain. States pain is constant and aching. Medication does help with pain. He requires prescription today...." Nursing Progress Note, dated 2/18/22 at 11:28		harm existed related to the cited deficient practice. I further request the severity be amended to a severity of D. The facts related to CNA's behavior are not in debate with regards to this IDR. The facility fully cooperated with ISDH with the investigation and did, in fact, not only substantiate the allegation of abuse, but terminated the employee and filed a formal complaint against his license with the Indiana Attorney General's Office. There are two critical facts the 2567 fails to mention that are vital to the determination of the severity of the tag. First, no actual hard was committed and this was proven when none of the residents were determined to be harmed by physical or psychosocial distress. All of the verbal statements made by CNA did not cause a single resident to suffer from psychosocial distress. None of the residents affirmed psychosocial distress to any staff member or psych services when questioned. Further, although the residents directly affected did not approve of the CNA's conduct, they never once were in psychosocial distress. Also, the facility provided the ISDH surveyor with a negative wrist x-ray to prove the resident was not physically	

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	a.m., indicated a telehealth video visit was conducted for "...Chronic pain secondary to CVA (stroke) and hemiplegia ... [Resident 29] states he has severe, chronic pain after experiencing MCA/CVA. He states his pain is 10/10 without his Norco and relived to 6/10 with his medication. Pain described as severe, debilitating and constant located at his back right lower extremity [which would be his lower left leg]. He denies associated constipation. He has no other complaints today. No h/a, dizziness, confusion, lethargy, sob, cp/abdominal pain today. No other concerns .... [Resident 29's] Chronic pain is well controlled with Norco ...." Nursing Progress Note, dated 2/21/22 at 7:22 p.m., indicated Resident 29 complained of general right-sided pain, and received his as needed pain medication. Nursing Progress Note, dated 2/22/22 at 10:58 a.m., indicated Resident 29 complained of chronic right-sided pain he endorsed as "nerve" pain in the right arm/leg. Stated the pain was sharp at times and achy at other times. An order was placed to increase his Gabapentin. Nursing Progress Note, dated 2/25/22 at 5:09 p.m., indicated a telehealth video visit was conducted for general medical management and ongoing right sided pain in his upper and lower extremities. Pain had been present for several weeks and described and dull, achy, and progressive. The telehealth NP indicated the chronic pain and body aches were likely muscle atrophy/spasms related to his stroke and gave instructions to monitor pain and address if not improved in the next week. Nursing Progress Note, dated 3/15/22 at 11:00 a.m., indicated a telehealth video visit was		injured and had existing diagnosis related to his condition. Second, while conducting its investigation, ISDH was present when staff and residents informed ISDH that they had repeatedly informed the facility administrator, director of nursing, social service director, and all other staff members that they had not been truthful when questioned about whether abuse occurred in the past. In fact, a staff member and a current resident both made statements that they are of a culture that they do not “snitch” and never had any intentions of providing information that would assist the facility in an investigation that could substantiate abuse. The resident went further to state that she was transparent with the state because she receives Medicaid benefits and would always be truthful with the entity that pays her bills. However, she stated she never had any intentions of being truthful with the facility. The ISDH surveyor was present when several residents changed their stories to ultimately provide truthful facts to assist the facility. These same residents also informed the same ISDH surveyor that they had not been truthful with the facility in the past. This is very significant because had the facility had factual information, the outcome of	

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	conducted for regularly scheduled medical management and indicated Resident 29's pain was well controlled with the current medication regimen. Nursing Progress Note, dated 4/5/22 at 6:27 a.m., indicated Resident 29 complained of generalized leg pain and was administered medication which was affective. Nursing Progress Note, dated 4/7/22 at 11:02 a.m., indicated Resident 29 complained of generalized pain "all over," and was administered pain medication which was effective. Nursing Progress Note, dated 4/14/22 at 5:12 a.m., indicated Resident 29 complained of generalized leg and back pain and was administered pain medication which was effective. Nursing Progress Note, dated 5/4/22, indicated Resident 29 initially complained of pain in his left wrist after a transfer, a stat x-ray was ordered, additional pain medication, and ice were also ordered. A change of condition nursing progress note was entered on 5/4/22 at 6:07 p.m., which indicated, " ...On call ordered a stat [as soon as possible] x-ray of left wrist, ibuprofen, 600 mg (milligrams) every 6 hours as needed for pain and apply ice pack to left wrist every 2 hours off for 1 hour ...." A telehealth Nurse Practitioner (Np) visit was conducted on 5/4/22 at 7:37 p.m., using synchronous video call. At this time Resident 29's wrist was evaluated. " ... Left arm/wrist is noted to be in the extended position with moderate swelling/redness and limited ROM with wrist flexion due to pain/swelling ..." New orders were		their previous investigations would have likely resulted in different conclusions. The facility did everything it could with the facts that it had during all of its investigations. The facility could not have foreseen that residents and staff would be untruthful with statements. No residents suffered psychosocial or physical harm. For these reasons, the facility formally requests the severity of F600 be amended from G to D. Sincerely, Twyla Shaw, HFA	

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	given at this time to perform a STAT (immediate) x-ray, elevate, ice and immobilize until x-ray results returned, continue oxycodone every 6 hours as needed for pain, and complete a follow up x-ray for further assessment. A nursing progress note, dated 5/4/22 at 11:43 p.m., indicated Resident 29's left wrist was observed swollen shortly after dinner by his caregiver, an assessment of the affected left wrist was done, MD (medical doctor) on-call ordered a stat x-ray of the left wrist, ibuprofen, and ice pack as needed. Resident 29 indicated the swollen wrist happened during a transfer sometime on 5/3/22. The initial x-ray results were received, on 5/5/22 at 6:48 a.m. and indicated no definite radiographic evidence of acute fracture or dislocation, but if there were persistent symptoms, follow up x-ray may be obtained as clinically warranted. On 5/5/22 at 10:32 a.m., a telehealth video visit was conducted for follow up to Resident 29's continued complaint oof left wrist pain. The resident continued to endorse pain, swelling and limited range of motion (ROM) and stated he could not complete therapy due to the pain. Nursing Progress Note, dated 5/11/22 at 6:32 a.m., indicated Resident 29 complained of "arm pain," and was administered pain medication which was effective. Nursing Progress Note, dated 5/18/22 at 4:08 a.m., indicated Resident 29 was noted to be yelling out, and asked for his pain medication for his legs and wrist and stated, "I'm really hurting bad." Nursing Progress Note, dated 5/19/22 at 10:31 p.m., indicated Resident 29 continued to complaint			

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	of pain to his left hand, upon assessment swelling was noted, and an ice pack was applied. Nursing Progress Note, dated 5/20/22 at 5:46 p.m., indicated a telehealth video visit was conducted for pain management. Voltern gel was requested for pain relief which was ordered at that time. Nursing Progress Note, dated 5/33/22 at 8:11 a.m., Resident 29 continued to complain of pain in his left hand. The record lacked documentation that a follow up x-ray had been completed as indicated in the summary of the initial x-ray and follow up NP visit. Resident 29 had Pain Assessments completed upon admission on 2/7/22, 2/8/22 and again on 2/10/22. A Pain Assessment was completed on 5/4/22 after the allegation of abuse. Each assessment summarized Resident 29's pain as "generalized aching throbbing," "chronic all over." The 5/4/22 assessment indicated Resident 29's wrist appeared to be red and swollen. Actual worked nursing scheduled were reviewed and revealed CNA 23 had been on duty, assigned to the hall where Resident 29 resided on both 5/3/22 and 5/4/22. Resident 29's Point of Care (POC) responses entered by the assigned CNA caregiver who completed the tasks during that shift were reviewed from 5/3 to 6/3/22. On 5/3/22 and 5/4/22 CNA 23 transferred Resident 29. After returning from his suspension, CNA 23 transferred Resident 29 on 5/15, 5/19, 5/28, and 5/29. CNA 23 wrote a witness statement, dated 5/4/22, which indicated he had provided personal care			

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	and transferred Resident 29 into his wheelchair but never noticed any swelling or pain in his arm. CNA 23 indicated the last person to have physical contact with Resident 29 before he complained of pain was therapy, and therapy should have reported the injury. On 6/6/22 at 11:10 a.m., the Therapy Program Manager (TPM) was interviewed in regard CNA 23's witness statement and Resident 29's therapy participation. The TPM indicated even though he was new to the building, he had already heard rumors from staff and residents that CNA 23 had a bad mouth. He had heard the aid referred to as, "mouth of the south." The TPM worked with Resident 29 a couple of days after the incident and noted some swelling in his left wrist and hand, so when they worked, he had to be careful when repositioning in order not to cause additional pain. As this time, the TPM provided copies of Resident 29's therapy progress notes. A Physical Therapy (PT) note, dated 5/3/22 at 12:37 p.m., indicated Resident 29 had participated in PT with no complaints of pain and no indication of injury to his left wrist. A PT note on the following day, dated 5/4/22 [time-stamp not provided], indicated, " ...pt [patient] presented [with] increased swelling on Left hand and elbow, unable to perform standing...." A Speech Therapy (ST) note, dated 5/5/22 at 12:42 p.m., indicated, " ...resident seen in his room and up in his wheelchair. New injury to hand with no recollection of procedures in place to improve it ...." During an interview on 6/2/22 at 11:26 a.m., the			

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	Regional Director of Operations (RDO) indicated the facility planned to re-open the investigation into the abuse allegation related to Resident 29 and CNA 23. During an interview on 6/3/22 at 9:20 a.m., the RDO indicated Resident 29 had been sent to the hospital for further evaluation of his left wrist, but upon his arrival, indicated it was his shoulder that hurt instead. An x-ray had been completed on the left shoulder, and the hospital had not completed an x-ray on his left wrist. Resident 29 refused to be returned to the facility and insisted to be sent to a different facility. So, he was transferred the same day to a sister facility. Because an x-ray had not been completed on his wrist at the hospital, the RDO indicated another mobile x-ray would be completed as soon as possible. On 6/3/22 at 8:18 p.m., the x-ray results of Resident 29's wrist were received and indicated the presence of soft tissue swelling. 2. On 6/1/22 at 10:00 a.m., Resident 39 was interviewed. He indicated he had remaining concerns that CNA 23 was still working at the facility and continued to verbally abuse Resident 26, whose room was near Resident 39. Over the holiday weekend on 5/29/22, CNA 23 "went off" on Resident 26 again. Resident 26 had an incontinence accident and CNA 23 kept going up and down the hall and in and out of his room while getting him cleaned up screaming things like, "G------ it man! You're too old for this s---! I can't believe you s--- yourself again, you're a f------ baby man! I should be up at the track the way you you've got me running around like this!" This went on the whole time it took to get Resident 26 cleaned up. It was at least 10 minutes. Resident 39 indicated Resident 26 was so angry he was visibly			

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	shaking and asked Resident 39 to go with him to report it to management. Monday was a holiday, and no management was at the facility. So, first thing Tuesday morning Resident 39 went with Resident 26 to the Social Service Director (SSD). When they reported it to the SSD, she took over and notified the Administrator and Director of Nursing (DON). Resident 39 indicated all he knew at this time, was CNA 23 was suspended "again" but it probably wouldn't do any good since this was "like his 3rd suspension." On 6/1/22 at 10:10 a.m., Resident 53 was interviewed. She indicated she knew who CNA 23 was and she had the same concerns she had shared during the previous survey visit. Resident 53 indicated she did overhear CNA 23 yelling at another resident over the holiday weekend, 5/29/22, after he had an incontinence accident. On 6/2/22 at 9:35 a.m., Resident 26 was observed as he sat up in his bed. He indicated he did not like CNA 23 at all. CNA 23 screamed and yelled at him all the time because he would have accidents on himself. It embarrassed him because the whole hall could hear it. Resident 26 wanted to "get the hell out of this place," if he was going to be treated like that. Resident 26 indicated the last incident happened the previous weekend on 5/29/22. CNA 23 had yelled at him before as well, but he was fed up with it and wanted out of the building. During a follow up interview on 6/2/22 at 9:45 a.m., Resident 29 indicated, "we've been warning yall about him [CNA 23]." Resident 29 indicated he had heard CNA 23 yell up and down the hall, especially at Resident 26. The aid said things like, "I can't believe you f------ s--- on yourself! Man, I don't get paid enough to keep wiping you're a--			

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	like this!" It seemed like CNA 23 was "just burnt out," he had a really short fuse, and you did not want to be on the wrong side when it went off. At this time Resident 29's roommate indicated he heard CNA 23 yell up and down the hall all the time. It was really "off-putting," and he was thankful that he could still do most everything for himself because he did not want to have to ask CNA 23 for help. A state reportable incident was filed on 5/31/22 (two days after the incident occurred). The reportable indicated, Resident 26 reported the incident to the SSD. CNA 23 told him, "You are too d--- old to be doing this s--- you know. I should be at the Indy 500 the way you have got me running!" An investigation conducted and substantiated. The employee was terminated and reported to the Attorney General's office. Resident 39 and 26 both submitted confidential witness statements on 5/31/22 which were signed by the Administrator. During an interview on 6/2/22 at 10:50 a.m., Resident 26's family member indicated Resident 26 had seemed more depressed lately when she talked with him on the phone. The last conversation they had, there was an increased sense of urgency in Resident 26's voice when he told her he wanted to move out of the facility because of a recent incident between him and a staff member. Resident 26's family indicated she lived in another state at the moment but was looking for available placement for Resident 26 to transfer closer to her. On 6/2/22 at 2:05 p.m., with the Administrator present Resident 26 was re-interviewed and confirmed the story that CNA 23 had yelled and			

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	cursed at him for having an accident on himself. Resident 26's record was reviewed on 6/2/22 at 3:00 p.m. The most recent comprehensive assessment was a quarterly MDS assessment dated 3/9/22. According to the MDS he was moderately cognitively impaired with a BIMS score of 11 of 15. There were no recently coded concerns related to behaviors, and he was frequently incontinent of both bowel and urine. 3. On 6/1/22 at 10:10 a.m., Resident 53 was interviewed. She indicated she knew who CNA 23 was and she had the same concerns she had shared during the previous survey visit. Resident 53 demanded CNA 23 to come off her caregiver assignment after he "roughly" transferred her from her wheelchair to her bed, and her knee "whacked the side of the bed." Even though CNA 23 came off her assignment, he still came in to help her roommate, Resident 25. CNA 23 "cussed at her all the time for falling." Even though Resident 25 was deaf, Resident 53 did not like to hear it, and it upset her on behalf of her roommate. On 6/2/22 at 2:00 p.m., with the Administrator present Resident 53 was re-interviewed and confirmed the previously stated allegation that CNA 23 was verbally abusive toward her roommate, Resident 25, and that because he had hurt her knee a while ago during a transfer, she had him taken off her assignment. Resident 53's record was reviewed on 6/2/22 at 3:00 p.m. Resident 53 had a current diagnosis which included but was not limited to bipolar disorder, and a comprehensive care plan (dated 3/10/22) for manipulative behaviors related to the bipolar disorder, the record lacked documentation of the recent or ongoing behaviors.			

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	Resident 53's most recent comprehensive assessment was a significant change Minimum Data Set (MDS) assessment dated 5/16/22. According to the MDS she was cognitively intact with a BIMS (brief interview for mental status) score of 14 of 15, with no recently coded concern related to behaviors. 4. On 6/2/22 at 2:10 p.m., with the Administrator present Resident 9 indicated she had wanted to say something when survey was at the facility the last time during the Resident Council Meeting, but everyone had been treating her so "good," she was afraid to say anything about CNA 23, and then have staff retaliate against her. Resident 9 indicated, yes, it was true, CNA 23 was really mean, and went all around cussing and fussing at everyone. Resident 9's room was near Resident 26's and Resident 30's. Resident 9 heard CNA 23 yell at Resident 26 for having an accident on himself and had overheard him belittling Resident 30 for being "too fat." On 6/2/22 at 2:20 p.m., with the Administrator present Resident 30 with hesitation and anxiety, asked "Do I have to tell the truth?" The Administrator patiently and gently encouraged her to tell the truth. Resident 30 indicated, yes, CNA 23 was mean and told her things like she was too big, and made her roommate cry all the time. During an interview on 6/3/22 at 12:25 p.m., the RDO indicated another state reportable had been submitted related to a new allegation. When the Administrator conducted a follow up interview with Resident 9 related to the previous verbal abuse allegation, Resident 9 indicated she overheard CNA 23 say sexuality explicit things towards Resident 30. He told the resident he			

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	wanted to "stick his d--- between her t------ and get off that way." During a follow up interview on 6/3/22 at 2:26 p.m., the RDO and Administrator indicated the investigation into the sexual verbal abuse had been conducted and would be substantiated. The RDO and Administrator both agreed they knew Resident 9 very well, had no reason to doubt her, and trusted what she said was true. The investigation was substantiated, and the CNA would be terminated. During the investigation it was determined the statement CNA 23 made to the resident was delivered with the intention of being a joke, and they did not believe he had any plans to act against Resident 30 or any other resident. The content of the joke, and language of the joke however were absolutely intolerable and inappropriate. Resident 9's record was reviewed on 6/2/22 at 3:00 p.m. The most recent comprehensive assessment was a quarterly MDS assessment dated 4/11/22. According to the MDS she was cognitively intact with a BIMS score of 15 of 15 and there were no recently coded concerns related to behaviors. Resident 30's record was reviewed on 6/2/22 at 3:00 p.m. The most recent comprehensive assessment was a quarterly MDS assessment dated 2/125/22. According to the MDS she was cognitively intact with a BIMS score of 13 of 15 and there were no recently coded concerns related to behaviors. Resident 30 had a comprehensive care plan dated 3/23/22 for manipulative behaviors, the record lacked documentation of any recent or recurring behaviors. CNA 23's employee file was requested and			

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	provided by the Administrator on 6/3/22 at 11:25 a.m. and reviewed at this time. A CNA specific job orientation checklist was present from the time of CNA 23's hire on 8/13/20. The orientation checklist only included the CNA's initials and signature. There was no preceptor's initials or signature to signify the individual skills had been checked off, and there was no nursing supervisor signature, that his skills had been checked off. Further his file included 5 Disciplinary Action Reports, 3 of which were specifically related to allegations of abuse or mistreatment. A Disciplinary Action Report, dated 4/4/22, indicated he had been suspended for "allegations of verbal abuse." A Disciplinary Action Report, dated 5/4/22, indicated he had been suspended for "allegations of abuse." A Disciplinary Action Report, dated 5/31/22, indicated, "suspended, waiting results of investigation." During an interview on 6/2/22 at 10:30 a.m., the RDO indicated there was no specific policy that included details or spoke to employee disciplinary actions. That staff disciplinary actions would be made as needed on a case-by-case incident. However, it was his personal expectation that there was a no tolerance policy when it came to abuse. If someone was suspended for abuse, then they would be termed (fired). As part of the plan of correction (POC) for two abuse deficiencies related to reporting abuse, and			

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	investigating abuse cited during the annual recertification survey on 4/13/22, the Administrator/DON/Designee were to educate staff on the Abuse Prevention Program. In-Services were held on 5/5/22 and 5/6/22. The sign in sheets for the In-Service were included in the POC binder and indicated handwritten in all caps at the top of the page, "ALL EMPLOYEES." CNA 23 was not included on any of the 4 pages of staff sign-ins. As a part of the POC for two previously cited abuse deficient (F609 for reporting abuse, and F610 for investigating abuse), the Administrator/DON/Designee educated staff on the Abuse Prevention Program. In-Services were held on 5/5/22 and 5/6/22 and included the following material which served as the current facility policy and expectation: An undated policy titled, "Abuse Prevention Program." The policy indicated, " ...This facility will not tolerate resident abuse or treatment [mistreatment] by anyone, including staff member, other residents, consultants, volunteers, staff or other agencies, family members, legal guardians, friends of other individuals ... Abuse: the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being ... Verbal Abuse: Any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability ... Sexual Abuse: Including, but not limited to, sexual harassment,			

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	sexual coercion or sexual assault. Physical Abuse: hitting, slapping, kicking, etc. It also includes controlling behaviors through corporal punishment ...." An undated policy titled, "Dignity." The policy indicated, " ...As an extension of appropriate interactions between staff and residents, the following will be practices of the facility. NOTE: Depending on scope and severity; what appears to be a dignity issue often can be interpreted and even meet the criteria for abuse. Conversations 1.) Staff will be polite and respectful at all times. 2.) Staff will not speak in a manner that could be interpreted as even minimally condescending/critical or argumentative not in a volume any louder that is absolutely necessary as this can be interpreted as meting criteria for abuse. 6.) Staff will not make reference to a malodorous field caused by the resident. This includes commenting on the smell of bad breath, body odor, urine or BM [bowel movement] ... this could cause the resident embarrassment. Care 1.) Staff will maintain resident privacy during all personal care ... 3.) Should a resident have an episode of incontinence, staff will change them upon discovery of the episode ...." 3.1-27(a)(1) 3.1-27(b)			
F 0679 SS=E 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			

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	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 observations, interviews, and record reviews, the facility failed to ensure an ongoing activity program was being implemented as scheduled, failed to ensure accurate logs were maintained to monitor resident participation and failed to ensure that activities were accurately audited to monitor randomly selected activities over each day of the week. This deficient practice had the potential to effect 49 of 49 residents who resided in the facility. Findings include: 1. On 6/1/22 at 9:30 a.m., the plan of correction (POC) for lack of activities in the facility was reviewed. The POC indicated the Activity Director (AD) was re-educated by the Administrator (ADM) on the Activity Policy and the importance of following the activity calendar. The AD was also educated on the importance of including residents to see what was of interest to the residents and that this education was completed on 5/6/22. An outline of the AD's education included but was not limited to the inclusion of a weekly outdoor activity, more activities based on Holidays and special days, and those activities were to happen as scheduled. If activities could not happen as scheduled, it needed to be noted on the calendar with a reason why and the Administrator was to be notified. During an interview on 6/1/22 at 10:00 a.m., Resident 39 was observed as he laid in bed. He	F 0679	F 0679 – Activities It is the practice of this facility to ensure that activities mee the interest and needs of each resident. All residents have the potential to be effected; however, no harm came to any resident. Administrator and DON attended Resident Council on June 22nd, and asked them what they wanted to see done different in activities and were given several ideas. Then Social Services talked with a group of residents and had them to answer a list of questions in regards to what type of activities they liked individually. These ideas were taken to the Activity Director and will be incorporated into the Calendar. Administrator educated Activity Staff on June 30, 2022 as to activities being held per calendar, going and inviting residents to activities and assisting them if necessary; if a change of activities occurs that calendar needs to show that and a document why in binder, and ensuring that activities meets the needs and interest of all residents. They were also educated on documentation of resident attendance being accurate and true and on the new	07/06/2022

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	indicated activities were pretty much happening the same as it had been before. There were not many options or activities of interest to him. When asked about the recent Holiday and Race Weekend, (Memorial Day and the Indianapolis 500 race) Resident 39 indicated, they had put some decorations up. But that was up at the front of the building, and nothing was really decorated around the resident areas. They did not have any other special events recognizing the two big events. Resident 39 indicated he would have watched the race if it had been replayed, would have like some grilled out or cook-out foods. Resident 39 indicated no one talked with him about other activity ideas that he could recall. During an interview on 6/1/22 at 10:09 a.m., Resident 53 was observed as she laid in bed as she worked on a word search puzzle. Resident 53 indicated activities did not interest her because she did not like things like card games or crafts but would not mind going to sit outside if the weather was nice besides just for smoke breaks. She thought it would be nice to watch a movie on a big screen with popcorn and a coke. Resident 53 indicated no one had asked her about what other activities she would like so she just kept doing her puzzles. During an interview on 6/1/22 at 10:15 a.m., Resident 30 was observed as she sat in her wheelchair at the entrance of her room. Resident 30 indicated she liked to stay in her room a lot and watch people in the hall, but no one came down to give her puzzles, books, crafts etc. She watched TV sometimes, but the channels did not always work. On 6/1/22 at 2:35 p.m., the Activity Calendar outside of the Activity Room was observed. The		resident attendance log and documentation was completed if there was a need to change the activity calendar. This will be done 5 x week x 4 weeks, 4 x week x 4 weeks, 3 x week x 4 weeks, 2 x week x 4 weeks, weekly x 4 weeks, then monthly for 2 months. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved.	

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	scheduled activity was listed as "nail care" and the AD and an activity assistant were observed as they prepared and rolled a plastic bin of various items onto the memory care unit. No "nail care" activity was implemented as scheduled for the main population residents. During an interview on 6/2/22 at 10:50 a.m., Resident 26's family member indicated Resident 26 had seemed more depressed lately when she talked with him on the phone. The last conversation they had there was an increased sense of urgency in Resident 26's voice when he told her he wanted to move out of the facility because of a recent incident between him and a staff member. Resident 26's family indicated she lived in another state at the moment but was looking for available placement for Resident 26 to transfer closer to her. When she had been able to visit him, he was almost always in his room. She had never seen him in an activity. Sometimes he would watch TV in his room, but he needed help with the remote and for a while it was missing. She was not sure what kind of activities were offered but thought it would be good for Resident 26 to get out of his room and socialize. On 6/3/22 at 2:26 p.m., the ADM provided a copy of a revised Activity Calendar for the month of June. The Calendar indicated revision were made on 6/3/22 and listed the following activities for 6/6/22 (with no indication of the need for change): 10:30 a.m. - Hydration Cart/Snacks 1:00 p.m. - Game Show TV 2:30 p.m. - Bingo 4:00 p.m. - Outdoor Social hour On 6/6/22 at 9:20 a.m., the Main Population Activity Calendar was observed. The following activities were listed for the day without a			

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	notation of the revision to the 1:00 p.m. schedule activity being changed from "Game Show TV" to "Bingo." 10:30 a.m. - Hydration Cart/Snacks 1:00 p.m. - Music 2:30 p.m. - Bingo 4:00 p.m. - Outdoor Social hour On 6/6/22 from 1:34 p.m., until 1:58 p.m., only one resident, Resident 9, was observed in the main dining room with her Boom-Box as she played loud, hip-hop/rap music. The Memory Care activity room was observed through the glass wall, and the Big Screen TV was off. There were two residents in the Memory Care Dining room sitting at a table with their eyes closed. No activity staff were observed inviting any residents to the "Music" activity, and neither TV in the Activity Room or Memory Care Dining Room had a "Game Show" on. During an interview on 6/6/22 at 2:34 p.m., the Receptionist indicated she had been asked to come help with activities in Memory care because one of the activity assistants had called off. The receptionist indicated she had not been asked to go invite any other residents to participate, but only to sit with the three men who were already in the dining room and help them color. A continuous activity observation was conducted on 6/6/22 from 4:03 p.m., until 4:25 p.m., to ensure the inclusion of the weekly outdoor activity was implemented as scheduled. At 4:03 p.m. Bingo had ended, and Resident 9 resumed playing music on her Boom-Box. No activity staff were observed. At 4:10 p.m., no activity staff were observed on the 100 or 300 halls to invite residents to the outdoor activity.			

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	At 4:15 p.m., no activity staff were observed on the 100 or 300 halls to invite residents to the outdoor activity. At 4:17 p.m., the AD entered the Activity Room and sat down at her desk with a Styrofoam beverage in her hand. At 4:20 p.m., the AD left her desk and walked onto the Memory Care unit. At 4:24 p.m., the AD gathered 6 Memory Care residents and escorted them outside into a patio-courtyard area. On 6/7/22 at 10:00 a.m., the Activity Calendar outside of the Activity Room was observed and listed the following activities (with no indication for the need to change): 10:30 a.m. - Current Events 11:00 a.m. - Sorry (a card game) 1:00 p.m. - Music 2:30 p.m. - Card Games During a continuous observation on 6/7/22 from 10:03 a.m., until 11:28 a.m., the following was observed: From 10:18 a.m. until 10:38 a.m., the AD and an activity assistant prepared snack carts and took them to the Memory Care unit, therapy gym, and the 300-hall offering Hydration/Snacks to several residents. At 10:58 a.m. the Activity Assistant attempted to turn on the big screen TV in the Memory Care dining room. She was unsuccessful throughout the continuous observation and the TV remained on a menu page. From 11:09 a.m., until 11:23 a.m., the Activity Assistant set up coloring pages for two residents in the Memory Care dining room, then sat down			

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	and scrolled on her personal cell phone, without engaging the residents. At 11:24 a.m., the AD entered the Memory Care dining room, (the assistant put her phone away), and the AD sat down with a card game and began a card game activity. At 11:28 a.m., a third resident entered the dining room and approached the table to play the card game as the Activity Assistant exited the Memory Care unit and returned the Activity Room. During an interview on 6/7/22 at 11:45 a.m., with the ADM present, the AD indicated, she had recently passed an Activity Director class and obtained her Activity Directors Certification. As a part of her plan of correction from the previously cited deficiency, she had received additional training which included, but was not limited to, adding more of a variety of activities, the addition of outdoor activities as weather permitted, special events, off campus outings etc. In order to ensure activities happened as scheduled when staff called in, the AD indicated she had to pull from other departments like nursing, if there were any aids available to help. She asked Housekeeping staff or the Receptionist to come to help. A second part time assistant had recently been hired, but the department was still in need of another assistant. In order to invite, gather, and encourage residents to come to scheduled activities, the AD indicated every resident had a calendar posted in their room, and the activity staff also went down and reminded residents of upcoming activities and invited them to come and assist them (if necessary) to the activity when it was time. If an activity could not happen as scheduled, the AD indicated it would need to be re-scheduled if appropriate, or another			

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	activity would need to be added in its place. The revision would be made to the main calendar posted outside the Activity Room so passing residents would be aware. Activity staff would also let residents know about the change and invite them to the newly scheduled activity instead. There was a disclaimer on the calendar itself that reminded residents that activities were subject to change. The Activity staff were to go room to room and ensure items for self-directed activities were available as residents requested. The AD combined the recent holiday and local race day. They put up race car decorations and the Head cook had prepared a BBQ themed meal. She did not know if the race was put on any TVs when it was aired later in the evening. The AD indicated she only had one resident who was one-on-one, Resident 10. She would provide hand massages for him, and aromatherapy. The AD indicated it seemed like the only activities residents in the main population cared about was being able to go out and smoke and anything to do with food. When she tried to incorporate the outdoor activity, no one would come. The AD indicated, yesterday for the scheduled "Outdoor Social Hour" activity that she had stood by the back door (the same exit and outdoor space used for smoking breaks) and waited for at least 15 minutes for any residents that wanted to participate, but no one came. So instead, she went to the Memory Care unit and took some of them outside. 2. On 6/6/22 at 12:16 p.m., the Activity Participation Log Binder was reviewed. There was a monthly calendar for each resident that was highlighted according to the following key: Pink-participated, Orange- unavailable, and Yellow-refused.			

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	Resident 29's participation log was reviewed and indicated he had participated in every activity over the weekend on 6/4 and 6/5. Resident 29 however, had been discharged to the hospital on 6/3/22 for evaluation and then was eventually transferred to a sister facility the same day. Resident 26's participation log was reviewed and indicated he had participated in every activity on 6/6/22. However, Resident 29 was observed periodically throughout the day and remained in his room. Specifically, during the above outlined continuous observation of the Outdoor Social Hour, Resident 26 was never invited to participate. Resident 22's participation log was reviewed and indicated she had already participated in every activity for the following day on 6/7 which had not occurred yet. Resident 9's participation log was reviewed and indicated she too had already participated in every activity for the following day on 6/7 which had not occurred yet. Resident 53's participation log was reviewed and indicated she was unavailable for the 6/6 Outdoor Social Hour, however, during the above outline continuous observation, Resident 53 was never invited to participate in the activity and was available as she remained in bed throughout the afternoon. Resident 39's participation log was reviewed and indicated he was unavailable for the 6/6 Outdoor Social Hour, however, during the above outline continuous observation, Resident 39 was never invited to participate in the activity and was available as he remained in the facility throughout the day.			

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	3. On 6/1/22 at 9:30 a.m., the POC indicated the AD was re-educated on the Activity Program and the activity program would be audited by the Social Services Director and/or designee to ensure activities were occurring as scheduled for the following duration of time: 5 days a week for 4 weeks 4 days a week for 4 weeks 3 days a week for 4 weeks 2 days a week for 4 weeks weekly for 4 weeks; then monthly for 2 months. The audit tool was reviewed. The Administrator/Activities designee had been crossed out and handwritten it its place was "Social Services" as the designated auditor. However, 11 of the 19 entries were signed off by the ADM, 3 entries were signed off by the DON and 1 entry was signed off by the ADON. The remaining 4 entries were not initialed or signed off by the designee. Seven of the nineteen entries were music, which accounted for 36% of the audited activities. The revised activity calendars, which were previously provided by the ADM on 6/6/22 at 12:16 p.m., were reconciled with the Activity Audit Tool. On 5/12/22, the ADM audited the 2:30 p.m. "Price is Right" as "occurring as scheduled." However, the scheduled activities on 5/12/22 did not include "Price is Right" as an activity, and there was no revision about the calendar having been subjected to change. On 5/18/22 the ADM audited the 2:00 p.m. activity as "occurring as scheduled." However, the			

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	scheduled activities on 5/18/22 did not include a 2:00 p.m. activity, only Bingo, which was at 2:30 p.m. On 5/27/22 the ADM audited and activity "[An] Planet' [Animal Planet?], with no specified time. However, the scheduled activities on 5/27/22 did not include anything related to "planets." During an interview on 6/7/22 at 10:45 a.m., the Social Service Director (SSD) indicated she was the designated staff member who was been appointed to assist the AD and audit activities as a part of the POC. The SSD indicated she had been signing off the audit sheets to ensure that activities were occurring as scheduled. During her audits she had found no discrepancies. The SSD indicated she only completed audits during her regular work hours which were Monday through Friday 8:00 a.m., until 5:00 p.m. She did not know if the activities were being audited over the weekend, but thought they should be, in order to ensure that activities were happening as scheduled across all days of the week.4. On 6/1/22 at 10:00 a.m., no activities were observed in the memory care (MC) area. On 6/1/22 at 11:40 a.m., no activities were observed in the memory care (MC) area. On 6/1/22 at 2:35 p.m., no activities were observed in the memory care (MC) area. On 6/1/22 at 2:43 p.m., Activity Assistant (AA) 9 was observed in the MC area. She had just turned on an aromatherapy light, the wax had not started to melt. The rolling cart had drinks, 6 cupcakes, and one-serving graham crackers packets. On 6/2/22 at 9:36 a.m., no activities were observed			

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	in the memory care (MC) area. Music was playing in the empty main dining room. During an interview, on 6/2/22 at 11:17 a.m., AA 9 indicated she was preparing a rolling cart to take activities to MC. She had coloring books and pencils, drinks, and snacks. She indicated there were 5 to 6 residents who sometimes did activities with her, the other residents needed to be shown how. She indicated the activities from the calendar were subject to change. On 6/2/22 at 11:20 a.m., a June MC Calendar was requested from the AD. It was not received until 6/6/22 as a revised version of the MC Calendar. During an interview, on 6/2/22 at 11:25 a.m., the Activities Director (AD) indicated, one day last month, she and AA 18 did a Walmart day trip. She indicated the facility bus could hold one person in their wheelchair and had 5 other seats for other residents to go. On 6/2/22 at 1:24 p.m., no activities were noted in the main area. On 6/2/22 at 1:25 p.m., in the MC area, AA 9 was providing drinks and snacks. Three MC resident were observed with coloring books and colored pencils. AA 9 indicated she would do one-on-one room visits with the remainder and MC residents. These room visits usually were about 10-15 minutes each. On 6/2/22 at 1:43 p.m., MC Resident 8 indicated there were no activities available in the MC area. He would have liked books to read, and he mentioned his three favorite authors. No one came to his room for one-on-one activity time.			

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	Resident 8's personal activity tracking calendar indicated he had attended multiple activities. a. On 6/1/22, it indicated he attended hydration, Court TV, and aromatherapy. b. On 6/2/22, it indicated he attended hydration cart/snacks, soulful melodies, and music. c. On 6/3/22, it indicated he attended hydration cart/snacks, flash back Friday, and easy listening. d. On 6/6/22, it indicated he attended hydration cart/snacks. On 6/2/22 at 2:01 p. m., MC Resident 31 indicated playing cards was available. He like playing a card game called Spades, but there was no one to play it with him. Resident 31's personal activity tracking calendar indicated he had attended multiple activities. a. On 6/1/22, it indicated he attended hydration, Court TV, and aromatherapy, game night and Pastor Price. b. On 6/2/22, it indicated he attended hydration cart/snacks, soulful melodies, and music. c. On 6/3/22, it indicated he attended hydration cart/snacks, flash back Friday, and easy listening. d. On 6/6/22, it indicated he attended hydration cart/snacks. On 6/2/22 at 1:48 a.m., MC Resident 53 was observed to have no personal TV. She indicated she did not watch her roommate's TV either. She just laid in her bed all day. She indicated no one came to her room to do activities. She would like to have drug store reading glasses because she liked to read mystery books. No mystery books were noted in her room. Resident 53's personal activity tracking calendar indicated he had attended multiple activities. a. On 6/1/22, it indicated she attended hydration,			

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	Court TV, and aromatherapy. b. On 6/2/22, it indicated she attended hydration cart/snacks and soulful melodies. c. On 6/3/22, it indicated she attended hydration cart/snacks and easy listening. d. On 6/6/22, it indicated she attended hydration cart/snacks. On 6/2/22 at 2:07 p.m., Resident 3 indicated the facility did not provide activities. He had his family to bring his own personal books. On 6/2/22 at 2:15 p.m., four unidentified residents were observed in the main dining room. Po-ke-no (board game) was in front of them. A current policy, titled, "Activities Program," with no date, was provided by the Administration (Admin) on 6/6/22 at 2:12 p.m. A review of the policy indicated, " ...It is the policy of the facility to provide an ongoing program of Activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of the residents ...Facility will offer activities both individual and group to enhance the physical, mental and psychosocial well-being of residents ...Facility will provide activities that promote self-esteem, pleasure, comfort, education creativity, success and independence ....Facility will provide a 1:1 [one-on-one] program for residents who are unable or who desire not to attend or join group activities ...Facility will provide activities that are appropriate for residents related to their interests ...Facility will develop specialized activities for residents with Alzheimer's disease (progressive disorder of brain deterioration) and/or dementia related conditions ...."			

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	This deficiency was cited on 4/13/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-33(a) 3.1-33(b)(8) 3.1-33(c)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observations, interviews, and record reviews, the facility failed to ensure a new pressure ulcer was reported to the physician, Director of Nursing (DON) and the residents responsible party, which caused a delay in treatment for a resident with a history of pressure ulcers in the same location for 1 of 3 residents reviewed for skin integrity and pressure ulcers, (Resident 25). Findings include: On 6/1/22 at 9:30 a.m., a Post Survey Revisit (PSR) was opened. As part of the Plan of Correction	F 0686	F0686-wounds Resident #25 had no adverse outcomes related to the deficient practices. Area on her bottom has been addressed by the Wound NP, which per the wound NP is an abrasion and not a pressure area or a DTI and area is healing well. All residents had the potential to be effected; however no other residents were effected. DON/designee will educate all staff on new areas and who to call (Doctor/NP, family,	07/06/2022

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	(POC) for a previously cited deficiency, skin assessments were completed on all residents, which included Resident 25 on 4/4/22. At that time, Resident 25 had no open areas, or skin integrity concerns. An additional piece of the POC included the re-education and in-service training provided to nursing staff on the topics which included, but were not limited to, procedures for Skin Assessments. Licensed Practical Nurse (LPN) 19's name was included on a list titled, "Alpha Home Nurses" with a handwritten notation which indicated, " ...Evening- Done 4/6/22 per [Assistant Director of Nursing (ADON) initials] ..." Materials provided during that in-service included but were not limited to a policy/procedure titled, "Skin Observation/Assessment (Shower/Bath). The Policy indicated, " ...Conditions that will be observed for include but are not limited to what appear to the care giver to be bruises, red areas, open areas, scratches, abrasions, blisters, discoloration, dry flaky skin, pressure ulcers, scars as well as any other condition of the skin. Only licensed nurses can assess the skin. If the care giver is not a nurse and they observe a change in the resident's skin, the care giver will notify the nurse immediately so that the nurse can perform a skin assessment and notify the physician/family as appropriate and also obtain as needed orders for treatment. Appropriate documentation and care planning will be completed as per policy. The residents name may need to be added to the list of residents to be reviewed and discussed in the S.W.A.T meetings going forward ... 3. Nurses will do skin assessments at least weekly (or as indicated)..." On 6/6/22 at 2:00 p.m., Resident 25 was selected as a sample resident to review for the POC related to		DON/designee), to get a new treatment, and document any new areas. DON/designee will conduct an in-service on wounds, and what to do when a new area appears. Nursing staff will be educated on reporting any new open areas. Audits will be completed daily by reading of the 24 hour report per DON/Designee daily x 5 days a week and a wound sweep will be done monthly x 6 months . Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved.	

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	the development of a new pressure ulcer. Her medical record was reviewed at this time. Resident 25 was initially admitted to the facility on 10/26/21. Her most recent re-admission was on 3/15/22 after a hospital stay. On 6/3/22 at 10:00 a.m., Resident 25 was observed being escorted out of the facility on a stretched by two EMT (Emergency Medical Technicians). The DON was present at that time and indicated Resident 25 was being sent out for a change of condition after a recent fall. At the time of this focused review on 6/6/22 at 2:00 p.m., the record lacked documentation of a recent census event to indicated Resident 25 had left to the hospital, and no re-admission nursing progress note to indicated when she had returned. Upon her re-admission from the 3/15/22 hospital stay, there were two identical "Weekly Wound Round" Assessments which indicated Resident 25 had re-admitted with a stage II pressure ulcer, (at stage 2, the skin breaks open, wears away, or forms an ulcer or a shallow crater in the skin) to her left trochanter hip which measured 4.5 cm (centimeters) long by 0.25 cm wide and 0.1 cm deep. While one assessment indicated the area was not healed; the second assessment indicated the area was healed. A nursing progress note, (entered by LPN 19) dated 5/18/22 at 9:16 p.m., indicated, Resident 25 had a new open area on her Left Buttock. It measured 5.8 cm long, by 5.2 cm wide, with no depth. The wound was cleaned with normal saline, and an adhesive island dressing was put in place. The record lacked documentation the physician, DON, and/or the resident's representative had			

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	been notified. The record lacked documentation that a new skin event or skin assessment was opened, and the record further lacked and additional monitoring of the new area until 6/2/22. A nursing progress note, dated 6/2/22 at 10:45 a.m., indicated, " ...open area noted with bathing by CNA, [Certified Nursing assistant], on call notified and treatment orders received ...." A new Weekly Wound Round assessment was initiated on 6/2/22 and indicated, Resident 25 had a Stage II pressure ulcer on her left trochanter hip which measured 4 cm long by 2 cm wide and had a depth of 0.1 cm. The assessment indicated "Telehealth" (without specification of the physician's name) ordered a new treatment for Calmoseptine every shift. The record lacked documentation that a Telehealth visit had been completed on 6/2/22 as stated in the Weekly Wound Round assessment. The most recent Telehealth visits for Resident 25 received were as follows: a. 5/31/22 for "possible falls" b. 5/13/22 after she fell from her wheelchair c. 5/10/22 for regularly scheduled medical management and review. At the time of the record review on 6/6/22 at 2:00 p.m., Resident 25's physician orders lacked documentation/reconciliation that Calmoseptine had been added to her physician orders set, so that it would automatically generate onto the Medication and/or Treatment Administration orders. On 6/6/22 at 3:00 p.m., Resident 25's pressure ulcer area was observed with LPN 11. LPN 11 assisted Resident 25 to the restroom, where she stood long			

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	enough for LPN 11 to pull her brief down for an observation of her left hip. There was no treatment in place at this time, (there was no evidence of fresh or dried calmoseptine, as "ordered"). The area was irregular in shape, with speckled peri-wounds of additional bruises. The area to her left hip appeared to be a Deep Tissue Injury (DTI). The right side of the wound was half-moon shaped and dark purple in color. There was a scant amount of serosanguineous drainage noted at center and bottom half of the wound. LPN 11 blanched the area, Resident 25 winced. LPN 11 indicated she did not know what kind of wound it was or how she got it, but it looked like a bad bruise. LPN 11 indicated, if a nurse needed to see what kind of treatment orders were required for new skin areas like that, they would look at the MAR for instructions. On 6/7/22 at 12:55 p.m., Resident 25's wound was observed a second time. The DON assisted Resident 25 to stand beside her bed. When the DON untied Resident 25's gown, the backside of her brief was visible. A moderate amount of brownish-red drainage was noted through the brief at the wound's location. The DON pulled the resident's brief down to visualize the wound. At first the DON indicated, "oh that's just a scar." She wiped her gloved finger across the wound and Resident 25 winced and attempted to pull her brief back up. When asked about the drainage which was seen through the brief, the DON indicated it was just the treatment of Calmoseptine. While dried, pink, calmoseptine was noted to the left side of the wound and peri-wound, the moderate brownish-red drainage was visible through the brief, and a shiny film of scant serosanguineous drainage was noted to the right side of the wound. At the center of the wound was an exactly rectangular shape, which			

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	155717	A. BUILDING 00 B. WING	06/07/2022

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	lined up nearly perfect to the height, width, and shape of Resident 25's electric wheelchair arm rest. Pieces of the arm rest padding had been ripped or torn away, which exposed a rectangular metal bar that was nearly identical to the shape at the center of her wound, as if a perfect impression had been made by falling onto it. The DON recanted her statement that the area was a scar, and then indicated the area may have developed from Resident 25's many falls. On 6/7/22 at 1:03 p.m., the DON indicated the facilities current policy was recently used as a piece of the POC re-education and in-service material, as also indicated above. The policy was undated, and titled, "Skin Observation/Assessment (Shower/Bath). The Policy indicated, " ...Conditions that will be observed for include but are not limited to what appear to the care giver to be bruises, red areas, open areas, scratches, abrasions, blisters, discoloration, dry flaky skin, pressure ulcers, scars as well as any other condition of the skin. Only licensed nurses can assess the skin. If the care giver is not a nurse and they observe a change in the resident's skin, the care giver will notify the nurse immediately so that the nurse can perform a skin assessment and notify the physician/family as appropriate and also obtain as needed orders for treatment. Appropriate documentation and care planning will be completed as per policy. The residents name may need to be added to the list of residents to be reviewed and discussed in the S.W.A.T meetings going forward ... 3. Nurses will do skin assessments at least weekly (or as indicated) ..." 3.1-40(a)(2) 3.1-40(a)(3)			

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F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record reviews, the facility failed to ensure a resident's PRN (as needed) narcotic pain medication was correctly documented when administered to avoid	F 0755	F0755-PRN Medication Res # 29 has discharged. All residents have the potential to be effected. No resident has had an	07/07/2022

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	the potential for drug diversion for 1 of 4 residents reviewed for medication administration (Resident 29). Findings include: On 6/1/22 at 10:40 a.m., Resident 29 was observed sitting up in his wheelchair beside his bed. At this time, he indicated his wrist hurt. His left wrist was observed resting across his lap. The wrist area was swollen and when Resident 29 lightly pressed it with his other hand he indicated it was tender to touch. Resident 29 indicated a CNA (Certified Nursing Assistant) had been too rough when him during a transfer a couple weeks ago, he "yanked him up" out of his wheelchair which caused his wrist to swell up and hurt. Resident 29 indicated he usually had pain on his left side because that was the side which was "taken out" during his stroke, but the pain in his wrist was new and had not gone away. He indicated he got pain medicine than only seemed to help sometimes. On 6/1/22 at 10:50 a.m., Resident 29's medical record was reviewed. He had a current physician order dated 2/7/22 for oxycodone-acetaminophen, (Percocet- a narcotic pain medication) 7.5 mg (milligrams) - 325mg with instructions to give 1 tablet as needed every 6 hours for pain. Resident 29's Controlled Drug Record/Disposition Forms were reconciled with his Medication Administration Records (MARS) and revealed more than 80 individual discrepancies. On 6/1/22 at 1:00 p.m., the facility was notified of the discrepancies and a Drug Diversion investigation was initiated. On 6/2/22 at 9:45 a.m., Resident 29 was observed a		adverse effect related to the deficient practice. Many PRN medications have ben made routine. Nurses and QMA's have been educated by DON or designee to make sure they are placing in the computer and on the narcotic sheet anytime a narcotic medication is given. Audits will be completed daily by checking the narcotic book against the EMAR on a daily bases x 5 weekly x 4weeks, then 4 days a week x 4 weekly, then 3 days a week x 4 weekly, then weekly x 6 months. Any deficiencies will be corrected immediately, and the findings of the audits will be documented and submitted at the monthly quality assurance committee meeting for further review or corrective action. The quality assurance committee will monitor monthly until they are confident the deficiency is resolved.	

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	second time. He was in the wheelchair in his room. At this time, he indicated someone had come around to ask him about his pain medicine and told him that his pain medicine was only PRN, or as needed, and he should have been asking for pain medicine when he needed it. Until that time, Resident 29 thought his pain medicine was schedule because of his chronic pain he always had in his left side because of his stroke. He was surprised to find out his medicine was not scheduled and wondered if that was why his wrist seemed to be hurting more lately. On 6/2/22 at 1:30 p.m., the Regional Nurse Consultant, (RNC) and the Regional Director of Operation (RDO) indicated the drug diversion investigation had been concluded and unsubstantiated. The RNC indicated it appeared that all the pain medication was accounted for, and accurately documented on the count sheet, but the nursing staff had failed to further document the administration on the MAR. Accurate medication administration had been addressed as a part of the Plan of Correction (POC) for the previously cited deficiency and the nursing staff had been in-serviced on the facilities policy and procedures. Part of the POC for this previously cited deficiency included, but was not limited to, ensuring nursing staff were re-educated on the proper administration and documentation of medications. In-Service training took place on 5/5/22 and 5/6/22. Of the nursing staff who received this in-service education, QMA (Qualified Medication Aide) 22, RN (registered Nurse) 22 and LPN (Licensed Practical Nurse) 21 were all three also noted to consistently incorrectly documents the administration of Resident 29's controlled substance.			

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	The in-service material included but was not limited to the review of a pharmacy policy titled, "Medication Administration Guidelines (Long Term Care Facilities)." The policy indicated, " ...6. Sign the MAR immediately after administering the medications ... document PRN, refused, withheld medications per facility policy ...." The current, but undated facility policy was also included in the POC. The policy was titled, "Policy and Procedure Medication Administration," and indicated, " ...to ensure that resident medications are administered in a timely manner and documentation is completed to substantiate administration ... medication administration records will be signed after for each medication administered to the resident ...." This deficiency was cited on 4/13/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-25(b)(3)			
F 9999 Bldg. 00		F 9999	THere was nothing listed for findings.	07/06/2022