STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 00 B. WING	03/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00402933. Complaint IN00402933 - No deficiencies related to the allegations are cited. Survey dates: March 6, 7, 8, 9, 10, and 13, 2023 Facility number: 000269 Provider number: 155400 AIM number: 1002667720 Census Bed Type: SNF/NF: 53 Total: 53 Census Payor Type: Medicare: 1 Medicaid: 44 Other: 8 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 19, 2023.	F 0000		
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family			

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

Jamey Kleva | Health Facility Administrator | 04/03/2023

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	members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.			
	Based on interview and record review, the facility failed to respond to, and resolve, Resident Council care concerns in a timely manner. Findings include: Facility Resident Council minutes were reviewed on 3/8/23 at 9:15 a.m., and indicated the following:	F 0565	F565 It is the practice of this facility to respond to , and resolve, Resident Council care concerns in a timely manner. 1. Corrective actions accomplished for those residents found to be affected by the alleged	03/30/2023

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	Resident Council Minutes were reviewed by the Administrator only on 4/28/22 and 11/28/22 in the last 12 months. The facility did not provide responses to the monthly resident council concerns identified in the minutes each month. The most recent Resident Council Meeting, held on 3/8/23 at 11:00 a.m., had discussed concerns with call light wait times of 45 minutes to one hour. Second shift call light wait times were reported as a concern more often than other shifts. Repeated Resident Council concerns, observed in the monthly minutes, were as follows: On 2/10/23 - lack of showers, poor attitudes of staff, timely call light response, and facility staff making residents feel afraid, humiliated, or degraded. On 1/13/23 - timely call light response, lack of facility responses to reported concerns with no reasonable explanation, facility management did not consider the views of the council, inability to get snacks at bedtime, facility staff making residents feel afraid, humiliated, or degraded, and resident rights were not respected and encouraged. On 12/9/22 - timely call light response, poor staff attitudes, lack of responses to requests and concerns with no reasonable explanation or follow- thru, residents not getting washed well, and rights were not respected and encouraged. On 11/28/22 - timely call light response on second shift, poor staff attitudes, no snacks at bedtime or when requested, and rights were not respected and encouraged.		deficient practice. a. Resident Council Minutes for March 2023 have been reviewed and outstanding concerns have been addressed completed 3/29/23. b. Education has been provided to Activity Department and/or Social Service for the completion of concern forms from the minutes and presented to the perspective departments for written follow up within 3 days. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. The Activity Director and/or Social Service Director will ensure that the resident council meetings will have written concern forms completed if needed and forwarded to the perspective department manager for written follow up within 3 days. b. Resident Council Minutes will be reviewed monthly and forwarded to Administrator for review and outstanding concerns addressed. 3. Measures and systemic changes put into place to ensure the at the alleged deficient practice does not recur. a. Resident Council Minutes going forward will be reviewed immediately by Activity Director and Social Service Director and grievances initiated as appropriate to address concerns.	

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	On 10/14/22 - timely call light response on second shift or staff would say they'd be right back but not return, facility staff making residents feel afraid, humiliated, or degraded. Unresolved old business of call lights and staff attitudes. On 9/22/22- timely call light response on second shift, poor staff attitudes where they were dismissive and showed a lack of caring, and no evening snacks available. On 9/9/22 - timely call light response on second shift, the facility was "awful", facility staff making residents feel afraid, humiliated, or degraded, and they did not respond promptly to the resident's views or recommendations. Call light response times and staff attitudes were not resolved from previous meeting. During a meeting with the Resident Council group, on 3/8/23 at 11:00 a.m., the following concerns were indicated during confidential interviews: The facility lacked prompt responses to the Resident Council concerns. Unresolved items of concern over the course of several months included completion of showers, extended call light wait times, dismissive attitudes of staff, availability of snacks, and the continued failure of addressing concerns identified by the resident group. Call light wait times could be over an hour, with the majority of longer wait times being experienced between 6:00 p.m. and 10:00 p.m. During this time frame, due to the extended call light wait time, residents would start banging on		b. Completed grievances and resident council minutes will be forwarded to the Administrator for review and resolution. c. Resolutions will be communicated in writing to the next council meeting, or sooner if indicated. 4. The corrective action will be monitored to ensure the alleged deficient practice does not recur and quality assurance measures put into place are: a. Resident Council audit will be conducted by SS and/or Designee and reported to Administrator monthly x3 or until determined substantial compliance has been achieved. If any discrepancies are noted, then immediate action will be taken to correct. b. The findings from these audits and any corrective actions taken will be discussed during quarterly QA meetings and the current plan revised, as warranted.	

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	the walls and yelling out, in an effort to try to get someone to answer their call lights. The staff members would initially come to the room, deactivate the call light, and tell the resident they would be back to assist them. Often, they did not return back to the room for over an hour. A resident had urinated on himself while he waited over an hour for the call light to be answered. Staff members were observed on their phones while a particular call light had been on for an hour. Snacks were improved in the evenings, but it had gotten bad again. A roommate who required staff assistance for toileting had to wait over an hour for help, and sometimes up to two hours. This practice had resulted in several episodes of incontinence. When the call light was answered, she was told she had to wait for her turn. They used to have a shower aide, but now residents were not getting their showers twice a week or according to their preference. A resident had received a shower on 3/7/23, which was her first shower in three weeks. Another resident had not received a shower twice a week since October 2022 and another resident had not had a shower in the last 10 days. On 2/6/23 and 2/7/23, the pantry was empty when snacks were requested. This remained an unresolved concern as well. When concerns were voiced by the Resident Group, they were not made aware of what action was in place to solve the problems.			

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	Residents felt degraded by some of the staff members, and their rights were not encouraged - they often felt dismissed. During an interview on 3/8/23 at 3:29 p.m., the Clinical Supervisor indicated the Social Services Director would have the responses to the Resident Council concerns. During an interview on 3/9/23 at 11:04 a.m., the Social Services Director indicated a former staff member handled the resident council meetings. The Social Services Director handled only the regular grievances, and was uncertain how the Resident Council concerns were responded to. During an interview on 3/10/23 at 2:56 p.m., the Social Services Director indicated none of the Resident Council concerns were brought to them to address through the grievance process. During an interview, at the time of observation on 3/13/23 at 11:54 a.m., Certified Nurse Aide (CNA) 4 provided a tour of the resident snack pantry. Drinks were readily available. The snack cabinet had one box of cream of wheat and three personal sized toasted oats containers. The CNA indicated the snack cabinet should have contained peanut butter sandwich cookies, oatmeal cream pies, fudge rounds, cheese puffs, brownies, and pop tarts. None of these items were available. During a confidential employee interview, they indicated residents typically had not refused their showers and usually asked for them to be given. A few residents had called the facility because they felt like the call light wait time was too lengthy and they would get faster assistance by calling the phone.			

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	During a confidential employee interview, they indicated residents felt uncomfortable or demeaned because the facility had been dismissive and failed to follow-up on resident concerns brought to their attention for several months. During a confidential employee interview, they indicated on Tuesdays and Thursdays on the 100 Unit, there were too many showers scheduled on day shift to get all of them done. This information had been reported to the previous two administrators and the Director of Nursing, but nothing changed. Some of the residents had concerns with timely showers once or twice a week. They usually asked about their showers at the beginning of the shift to get reassurance they would be completed. During an interview on 3/13/23 at 1:59 p.m., Administrator 2 indicated she was unable to provide any Resident Council response forms. A current facility policy, dated 8/1/22, titled "Resident Council," provided by Administrator 2 on 3/13/23 at 1:59 p.m., indicated the following: "...POLICY INTERPRETATION AND IMPLEMENTATION 1. The purpose of the Resident Council is to provide a forum for: a. Residents, families and resident representatives to have input in the operation of the facility; b. Discussion of concerns and suggestions for improvement; c. Consensus building and communication between residents and facility staff; and d. Disseminating information and gathering feedback from interested residents... 5. The Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern.			

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	6. The Quality Assurance and Performance Improvement (QAPI) Committee will review information and feedback from the Resident Council as part of their quality review. Issues documented on council response forms may be referred to the QAPI Committee, if applicable (i.e., the issue is of serious nature or if there is a pattern, etc.)...." A current facility policy, dated 8/1/22, titled "Resident Concerns and/or Grievances," provided by Administrator 2 on 3/10/23 at 11:20 a.m., indicated the following: "...POLICY... It is the policy of this facility that resident or family concerns/grievances occurring during the resident's stay in the facility shall, whenever possible, be responded to by the designated Social Services worker or responsible Department Head closest to the cause of the concern/grievance. Regardless of which supervisor/department head responds, the Executive Director or his/her authorized representative shall review all complaints and agree with the actions taken towards resolution. Responses to resident/family shall be made as soon as possible and preferably immediately. Actions taken to resolve the complaint shall be made within 72 hours from the time the Concern/Grievance Form was received. Actions taken include contacting the resident and/or family with an explanation of the steps we are going to take to resolve the complaint and to ensure their satisfaction. Actions must be documented. It should be noted if the resident or resident's family continues to express a concern and in their view, the problem is not resolved, the Executive Director must be apprised of the situation and the Executive Director must keep the Director of Operations informed...."			

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	3.1-3(l)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to thoroughly investigate a staff to resident abuse allegation for 1 of 2 residents reviewed for abuse. (Resident 17) Finding includes: During an interview on 3/7/23 at 12:07 p.m., Resident 17 was seated in her electric wheelchair with a family member present, just outside of her room. She indicated LPN 6 had called her a "fat rat" over the last weekend. The resident had reported it to the Human Resources (HR) Manager. They suspended the staff member, but the staff member had returned to duty. She was concerned she would be treated differently because she had reported her concern. No one	F 0610	F610 It is the practice of this facility to thoroughly investigate any and all allegations of abuse. 1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. Resident #17 allegation of abuse was reported to the state agency per regulation guidelines and investigation was conducted. b. The HR Manager, Clinical Supervisor, and ADON have received disciplinary action for not following guidelines of reporting abuse allegations for	03/30/2023

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	had followed up with her on her reported concern. During an interview on 3/7/23 at 12:29 p.m., Administrator 1 and the Clinical Supervisor indicated they had not been made aware of a potential abuse allegation from Resident 17, regarding LPN 6 having had called her a "fat rat" over the weekend. During an interview on 3/7/23 at 12:34 p.m., the Human Resources Manager indicated no one had reported the allegation to her over the weekend. Approximately two weeks to a month ago, the resident had come to her and told her the nurses were not being nice to her. The resident would not give any names or specific details regarding what was said or done. The HR Manager had not documented this information or reported to anyone for further investigation, because she did not have any specific details related to the concern. She had asked the resident for a description of the person if she did not know their name. The resident told her the person who did it knew who they were and she would not provide any additional information. The resident had not said anything more about it to the HR Manager since that time, but maybe she should have reported this to someone for further investigation. Resident 17's clinical record was reviewed on 3/7/23 at 4:34 p.m. Diagnoses included major depressive disorder, recurrent moderate, essential primary hypertension, posttraumatic stress disorder, and generalized anxiety disorder. Her current medications included the following: fluoxetine hydrochloride (depression) 20 milligram (mg) once daily- take with 40 mg for a total of 60 mg daily, fluoxetine hydrochloride (depression) 40 mg once daily for depression- take with 20 mg for		investigations to be conducted timely. c. Any and all allegations of abuse reported by a resident or employee will promptly be investigated as required by regulation. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. All residents have the potential to be affected by this alleged deficient practice. b. Any and all allegations of abuse will be investigated per the regulation guidelines. All interviewable residents have been questioned regarding allegations of abuse and no new allegations of abuse have been identified. There have been no suspicious indications of abuse that have been observed on those residents who are not interviewable. 3. Measures and systemic changes put into place to ensure the at the alleged deficient practice does not recur. a. A mandatory in-service for staff was completed on _3/29/23_____ for Long-Term Care Abuse and Incident Reporting Policy including timelines and investigation procedures. b. All incidents will be reviewed during morning clinical review to determine for reporting and investigation procedures per	

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	a total of 60 mg daily, and buspirone hydrochloride (anxiety) 7.5 mg twice daily. A 1/30/23 physician's order was completed for a urinalysis, culture, and sensitivity for altered mental status two days after the alleged event. A quarterly Minimum Data Set (MDS) assessment, dated 2/7/23, indicated the resident was cognitively intact. Rejection of care behaviors were not exhibited. She required extensive assistance for bed mobility, transfers, and toileting and limited assistance for dressing and personal hygiene. She was dependent for bathing and utilized a wheelchair for mobility. She was always incontinent of bowel and bladder. A current care plan for false accusations toward staff was dated 6/24/22. Interventions included, inform family and follow-up with family as needed (6/24/22) and investigate accusations as needed (6/24/22). A current care plan, dated 6/28/21, indicated the resident received mental health services. Interventions included notify the physician and resident representative upon any significant change (6/28/21) and mental health services will be provided as ordered (6/28/21). A current care plan, dated 6/24/22, indicated the resident exhibited episodes of delusions. Interventions included ensure the resident's safety and gently explain their belief was false and introduce evidence to prove why it was not true (6/24/22). A Nurse's Note, dated 1/28/23 at 1:48 p.m., indicated the resident had signs of delusions. The resident accused the nurse of calling her a		regulations. c. The staff will be instructed to notify Administrator immediately of any alleged accusation of abuse per regulations. d. The Administrator will complete audit tool to ensure investigations are completed on accusations of abuse per regulations. This will be completed daily during stand up morning meetings for the 4 weeks, then 1 time weekly for a quarter, then monthly for the next 3 quarters. Any issues identified; immediate action will be taken to resolve. 4. The corrective action will be monitored to ensure the alleged deficient practice does not recur and quality assurance measures put into place are: a. The Administrator will complete audit tool to ensure investigations are completed on accusations of abuse per regulations. This will be completed daily during stand up morning meetings for the 4 weeks, then 1 time weekly for a quarter, then monthly for the next 3 quarters. Any issues identified; immediate action will be taken to resolve. b. The findings from these audits and any corrective actions taken will be discussed during quarterly QA meetings and the current plan revised, as warranted	

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	name, which did not occur. She got upset with another resident because he did not side with her about hearing the nurse call her a name. She stated it had occurred at the nurse's station. There was another nurse at the nurse's station as well. The clinical record lacked any documentation regarding the allegation, other than the alleged perpetrator's behavior note on 1/28/23. The clinical record lacked family and physician notification documentation of the alleged events on 1/28/23 and 3/7/23. During an interview on 3/10/23 at 9:49 a.m., the Clinical Supervisor indicated a report of a staff member who allegedly called a resident a name was considered potential abuse. The facility's investigation of the allegation consisted of the behavior progress note (documented by the alleged perpetrator), the urinalysis and urine culture results (ordered 2 days after the alleged event), and the care plans for false allegations and delusions. She indicated it was not appropriate for the alleged perpetrator in an abuse allegation to complete the investigation. During an interview on 3/10/23 at 12:39 p.m., the Clinical Supervisor indicated the facility lacked documentation of an investigation to include a statement made by the resident on 1/28/23. She had not spoken with the resident on 3/7/23 for a statement of her concerns when the Clinical Supervisor and Administrator 1 were made aware of the alleged abuse. Instead, she had reviewed the previous incident from the 1/28/23 behavior note and the associated urine culture, because it was the same verbiage. Facility abuse investigations were reviewed on			

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	3/10/23 at 11:20 a.m., and consisted of a one page summary of the allegation dates and a signature of the Clinical Supervisor. The summary indicated it had been typed on 3/10/23 due to a reference to the urine culture reviewed by the provider on 3/10/23. There were no individual statements from residents or staff members regarding alleged abuse. During an interview on 3/10/23 at 2:45 p.m., the Social Services Director indicated the allegations of abuse had not been reported to her by any residents or staff members. She was usually involved in the investigations and would have completed 4-5 interviews with cognitively intact residents for the investigation. Any staff who had an allegation of abuse reported to them should have reported it immediately to a manager. During an interview on 3/10/23 at 3:18 p.m., Resident 23 indicated he had been at the 100 Unit Nurse's Station approximately a month ago when Resident 17 alleged the nurse had called her a fat rat. No one had spoken to him about the original allegation, about a month ago. During an interview on 3/13/23 at 10:21 a.m., LPN 6 indicated Resident 23 had elevated his voice in response to Resident 17, who had tried to get him to side with her. Resident 17 had alleged the nurse had called her a fat rat. The LPN had reported it to the ADON over the telephone, just a few minutes after it had happened. She had not been suspended or relieved from her duties as a nurse while an investigation was underway because it did not happen. She returned to her regular shift and provided care for Resident 17 on the next day without any concerns. LPN 6 was not aware of who had investigated the allegation. No one has requested her to provide a statement,			

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	because it did not happen. She was unaware the resident had reported this on any further dates, as no one had spoken with her about it. During an interview on 3/13/23 at 12:07 p.m., the ADON indicated LPN 6 had reported the allegation of staff to resident verbal abuse to her during a phone call on 1/28/23. She had instructed LPN 6 to complete a behavioral form and document who the witnesses were. She also instructed her to notify the physician. The ADON had not reported the allegation on 1/28/23 to any further staff members for further investigation and did not have any documentation to provide. If the allegation had been unwitnessed , then the care giver would have been suspended pending investigation. It would have been reported to the Director of Nursing, Administrator, and a formal investigation would have been completed. The formal investigation would have included the witness interviews, statements from the resident and the employee, observations of the staff member with other residents, and interviews of other cognitively intact residents. The clinical record lacked documentation of physician notification on 1/28/23. During an interview on 3/13/23 at 1:59 p.m., Administrator 2 indicated an allegation of staff to resident abuse should have been investigated if it was not witnessed. She was uncertain if staff to resident abuse allegations had to have an investigation if the resident had a history of false allegations. She was concerned how the facility was protected if the facility was required to investigate/report allegations from residents with a history of false allegations. Residents with a false allegation history could have experienced abuse, as well as those without a history of false			

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	allegations. A current, undated, policy titled "ABUSE PREVENTION AND PROHIBITION POLICY," provided by Administrator 1 on 3/6/23 at 9:45 a.m., indicated the following: "PURPOSE... To ensure the resident's right to remain free from verbal, sexual, physical, and mental abuse, mistreatment, neglect, corporal punishment, involuntary seclusion, and exploitation. POLICY... This policy is to identify guidelines for preventing and reporting abuse or alleged abuse whether being Resident to Resident, Resident to Employee, or Employee to Resident. Residents residing in this facility will be treated with dignity and respect in accordance with their individual needs. They will not be subjected to physical, verbal, sexual, and mental abuse, corporal punishment, mental and physical neglect, involuntary seclusion, and exploitation... VERBAL ABUSE: *Threatening a resident verbally *Raising your voice to a resident in a scolding or abrupt manner * Using offensive terms / words * Gestured language that is disparaging... MENTAL ABUSE: *Deliberately embarrassing a resident * Belittling or mocking a resident * Saying anything to a resident which might cause him/her to worry or become alarmed * Creating a scene in the presence of a resident * Threats of punishment or deprivation... EMPLOYEE TO RESIDENT 1. Should an occurrence of abusive behavior be reported or witnessed, the Administrator shall be notified IMMEDIATELY. 2. The Administrator or his/her designee shall report to state / certified licensing agency within 2 hr [hours] of being notified. 3. The legal guardian of resident will also be notified of the incident and the results of the investigation. 4. The Employee should be suspended immediately pending the investigation and not allowed to return to facility until notified			

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	by Administrator or HR Director. 5. The Administrator or his/her designer, with assistance from the HR director, will conduct a thorough investigation of the incident within five working days. 6. The appropriate documentation will be reported to the state survey and certification agency as well as other related agencies within five working days of the incident. 7. The staff who witnessed or was made aware of the abusive incident will take immediate steps to protect thee involved resident from further abuse, including verbal, mental, physical, neglect, involuntary seclusion and/or exploitation...." 3.1-28(d)			
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.			

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	(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to hold care plan meetings, invite residents and/or representatives to care plan meetings, and to review and/or revise care plans in conjunction with care plan meetings for 4 of 4 residents reviewed for care planning. (Residents 39, 29, 16 & 23) Findings include: During an interview on 3/10/23 at 11:38 a.m., the Social Services Designee (SSD) indicated the facility was supposed to have care plan meetings on Wednesdays. Care plan meetings were not held due to resident behavioral concerns requiring all of the staff focus. Although the attendance record indicated otherwise, the interdisciplinary team did not meet together as a group nor with the resident and/or family/responsible party attending in person or via phone and discussed the residents plan of care for any of the facility's residents. Each department reviewed the care plan independently and then would sign the attendance form. She considered residents, families and/or responsible parties as having attended a care plan meeting because she had on-going, regular communications with them. 1. During an interview on 3/7/23 at 9:27 a.m., Resident 39's family member indicated she had not been invited to a care plan meeting since the resident's admission to the facility. She would have attended, even if it was by phone, had she	F 0657	F657 It is the practice of this facility to ensure a care plan conference meeting was completed and documented. 1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. Resident # 39 was scheduled for a care plan conference on __3/30/23___. Resident and Resident Representative have been invited to attend. b. Resident #29 was scheduled for a care plan conference on 3/30/23_____. Resident and Resident Representative have been invited to attend. c. Resident #16 was scheduled for a care plan conference on _3/30/23_____. Resident and Resident Representative have been invited to attend. d. Resident #23 was scheduled for a care plan conference on _3/30/23_____. Resident and Resident Representative have been invited to attend. (exhibit B) 2. To identify other residents who have the potential to be affected by the same alleged deficient	03/30/2023

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	been invited. Resident 39's clinical record was reviewed on 3/8/23 at 3:46 p.m. Current diagnoses included, Alzheimer's disease, dementia with psychotic disturbance, and depression. A 1/23/23, admission, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired, wandered daily, and required some level of staff assistance for all activities of daily living. A 2/22/23, 10:00 p.m., progress note indicated the resident fell and hit her head, which required an emergency room visit and a review of the resident's fall care plan. Behavioral progress notes on 2/1/23, 2/8/23, and 3/6/23, indicated the resident was displaying maladaptive behaviors, which could negatively impact the resident or others. This behavioral display required review of the resident's behavioral care plan. The clinical record lacked indication of the resident and/or their representative's invitation to a care plan meeting in conjunction to this assessment, nor of a care plan meeting ,which included a multidisciplinary team, held in conjunction with this assessment. 2. During an interview on on 3/9/23 at 1:35 p.m., Resident 29's family member indicated they had never been invited to a care plan meeting. Resident 29's clinical record was reviewed on 3/9/23 at 12:20 p.m. Current diagnoses included dementia, psychotic disorder with hallucinations, and Alzheimer's Disease.		practice. a. A complete review of all residents care plan conferences has been completed to ensure compliance. If issues are identified, immediate action will be taken to resolve. 3. Measures and systemic changes put into place to ensure the at the alleged deficient practice does not recur. a. The MDS Coordinator will provide a calendar of the MDS schedule to the Interdisciplinary Team monthly and updates will be provided as changes occur. b. Social Service Director and/or Designee will provide invitation to Resident and/Resident Representative to attend a care plan conference for the comprehensive and quarterly review assessments. Documentation of the invitation to the Resident and/or Resident Representative to the care plan conference will be included in the medical record. c. The care plan schedule will be reviewed daily during the stand up meeting. d. The Interdisciplinary Team was in-serviced _3/29/23_____ on participation of resident and family care plan conferences. e. The Administrator and/or Designee will complete an audit weekly for 3 months and then monthly for 3 quarters. If issues are identified, immediate action	

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	A 2/17/23,quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired, wandered daily, and required some form of staff assistance for all activities of daily living. The clinical record lacked indication of the resident and/or their representative's invitation to a care plan meeting in conjunction to this assessment, nor of a care plan meeting ,which included a multidisciplinary team, held in conjunction with this assessment. 3. During a telephone interview on 3/7/23 at 10:11 a.m., Resident 16's representative indicated she had last spoken with the facility in November of 2022. The facility used to have care plan meetings she could call in to attend, but she had not been invited to a care plan meeting in the last couple of years. She thought this had changed because of the pandemic, since she had not been invited in recent years. Resident 16's clinical record was reviewed on 3/9/23 at 8:37 a.m. Current diagnoses included the following: dementia in other diseases classified elsewhere, moderate, with mood disturbance, unspecified retention of urine, unspecified neuromuscular dysfunction of the bladder, and unspecified chronic kidney disease. A quarterly Minimum Data Set (MDS) assessment, dated 2/14/23, indicated the resident was severely cognitively impaired. The clinical record lacked indication of the resident and/or their representative's invitation to a care plan meeting in conjunction to this assessment, nor of a care plan meeting ,which included a multidisciplinary team, held in		will be taken to resolve. 4. The corrective action will be monitored to ensure the alleged deficient practice does not recur and quality assurance measures put into place are: a. The Administrator and/or Designee will complete an audit weekly for 3 months and then monthly for 3 quarters. If issues are identified, immediate action will be taken to resolve. b. The findings from these audits and any corrective actions taken will be discussed during quarterly QA meetings and the current plan revised, as warranted.	

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	conjunction with this assessment.4. During an interview, on 3/8/23 at 10:52 a.m., the resident indicated she had never attended a care plan meeting. Resident 23's clinical record was reviewed on 3/8/23 at 9:00 a.m. Diagnoses included conversion disorder with seizures, major depressive disorder, alcohol abuse with alcohol-induced mood disorder, and chronic obstructive pulmonary disease. The resident's 1/14/23 admission MDS assessment indicated the resident was mildly cognitively impaired. She exhibited verbal behavioral symptoms directed at others and rejection of care behaviors. A nurse's note, dated 1/12/23 at 7:25 a.m., indicated the resident was teary. She felt no one cared about her. She was always in pain. The clinical record lacked indication of the resident and/or their representative's invitation to a care plan meeting in conjunction to this assessment, nor of a care plan meeting ,which included a multidisciplinary team, held in conjunction with this assessment. The resident's current care plan had problems not reviewed during an initial care plan meeting. A current 1/1/22, policy titled "Comprehensive Resident Care Plans", provided by Administrator 2 on 3/13/23 at 4:56 p.m., indicated the following: "...The interdisciplinary plan of care will be developed through collaborative efforts of the Interdisciplinary Team and other health care professionals. It will be consistent with the medical plan of care and those disciplines that			

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	have direct involvement with the resident's care. The resident and/or family member will be involved in the care planning. ...The resident will have the right to participate in the development and implementation of his or her person-centered plan of care ... The Process will: a. Facilitate the inclusion of the resident and/or resident representative. ...Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessment...." 3.1-35(c)(2)(C) 3.1-35(d)(2)(B)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and			

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	(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure hygienic handling of the urinary catheter bag and tubing, and hygienic catheter care for 1 of 3 residents reviewed for catheters or urinary tract infections. (Resident 16) Finding includes: During an observation on 3/7/23 at 9:14 a.m., Resident 16 sat up in her recliner in her room, with her head nodded forward and her eyes closed. Her urinary catheter was hung underneath her wheelchair with the drainage bag directly against the floor. A barrier was not in place. During an observation on 3/7/23 at 3:49 p.m., the resident was seated in her wheelchair in her room. Her urinary catheter collection bag was hung underneath the resident's wheelchair, and rested against the floor beneath the wheelchair without a barrier. During an observation on 3/9/23 at 8:30 a.m., the resident was dressed and seated in her wheelchair in her room. Her urinary catheter bag was hung on her wheelchair frame. The urinary catheter tubing rested against the floor, underneath her	F 0690	F690 It is the practice of this facility to ensure hygienic handling of the urinary catheter bag and tubing, and hygienic catheter care. 1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. All Nursing staff was in-serviced _3/29/23_on proper handling of catheter bag and tubing and the hygienic catheter care 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. A complete review of all residents that have a catheter in place to ensure for proper handling of catheter bag and tubing along with peri care hygienic catheter care. No other issues were identified. 3. Measures and systemic changes put into place to ensure the at the alleged deficient practice does not recur.	03/30/2023

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	wheelchair, without a barrier. During an observation on 3/9/23 at 9:33 a.m., the resident remained seated in her wheelchair in her room with the door open. The urinary catheter tubing rested against the floor and without a barrier. This was visible from the 200 Unit hallway. Resident 16's clinical record was reviewed on 3/9/23 at 8:37 a.m. Current diagnoses included the following: dementia in other diseases classified elsewhere, moderate, with mood disturbance, unspecified retention of urine, unspecified neuromuscular dysfunction of the bladder, and unspecified chronic kidney disease. An order, dated 1/25/23, indicated to change the Foley (urinary catheter) 18 french x 30 cubic centimeter (cc) at bedtime every 30 days related to neuromuscular dysfunction of the bladder. A quarterly Minimum Data Set (MDS) assessment, dated 2/14/23, indicated the resident was severely cognitively impaired. She required extensive assistance for bed mobility, dressing, personal hygiene, transfers, toileting, and locomotion on the unit. The resident was always incontinent of bowel and required an indwelling urinary catheter device. Review of a hospital Emergency Room Discharge Instructions, dated 8/6/22, indicated the resident had been treated for a urinary tract infection. Review of the resident's positive urinalysis and urine culture (bacteria- Enterococcus Faecalis), collected on 2/14/23, indicated the resident required treatment for a urinary tract infection.		a. All nursing staff was in-serviced _3/29/23__ on proper handling of catheter bag and tubing and the hygienic catheter care. b. The DON and/or Designee will observe with documented results of staff handling of catheter bags and tubing along with peri care and hygienic catheter care. Any issues identified; immediate action will be taken to resolve. 4. The corrective action will be monitored to ensure the alleged deficient practice does not recur and quality assurance measures put into place are: a. The DON and/or Designee will complete audit 2x weekly x 4weeks, then 1 time weekly for a quarter, then monthly for the next 3 quarters. If issues are identified, immediate action will be taken to resolve. b. The findings from these audits and any corrective actions taken will be discussed during quarterly QA meetings and the current plan revised, as warranted.	

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	She had a current care plan problem of an indwelling catheter, last reviewed/revised on 2/4/23. Interventions included, provide catheter care according to physician orders - clinical record lacked catheter care orders (9/15/21) and observe/record/report to the physician for signs and symptoms of a urinary tract infection (9/15/21). During an interview on 3/9/23 at 10:32 a.m., Licensed Practical Nurse (LPN) 10 indicated a resident's urinary catheter bag and tubing should not have been against the floor when it was hung underneath the wheelchair. During an interview, at the time of an observation on 3/9/23 at 10:34 a.m., LPN 10 indicated the resident's urinary catheter bag and tubing was against the floor without a barrier while the resident sat in her wheelchair in her room. During an interview on 3/9/23 at 10:43 a.m., Certified Nurse's Aide (CNA) 11 indicated staff were required to ensure urinary catheter bags and tubing were not against the floor for urinary tract infection prevention. During a continuous observation of urinary catheter care on 3/9/23 at 1:07 p.m., CNA 11 was in the resident's room upon entry, with gloves on her hands. She placed a bag on the floor for soiled linens. She took her clean rags into the resident's shared restroom with her gloves on and used her right gloved hand to turn on the faucet as she held the rags in her left gloved hand. CNA 11 applied soap and water to one rag, applied water to another rag, and the third rag remained dry. She used her right gloved hands when she got the rags wet and then stacked the wet rags back onto the dry rag in her left hand. She turned off the			

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	faucet with her right gloved hand and carried the three rags back to the resident's bedside in her left hand and placed them directly on the residents Bible, on top of the resident's night stand beside the bed. A barrier was not utilized. She removed the resident's brief with her gloved hands and picked up the soapy rag off of the end table with her right gloved hand. She performed catheter care with the soapy rag front to back and cleaned the catheter tubing from the insertion site and moved away from the body. She placed the soiled rag in the bag on the floor. CNA 11 picked up the rinse rag off of the night stand with her right hand and rinsed the perineal area front to back and the catheter tubing by starting at the catheter insertion site and moved away from the body. Then she picked up the dry rag that was directly against the Bible with her right hand and dried the perineal area front to back and dried the catheter tubing by starting at the catheter insertion site and moved away from the body. The CNA had not used any hand washing, hand hygiene, or changed gloves during the catheter care observation. During an interview on 3/9/23 at 1:25 p.m., CNA 11 indicated she should have used a barrier on the surface before she placed the clean rags for urinary catheter care on Resident 16's night stand. During an interview on 3/9/23 at 1:31 p.m., LPN 10 indicated it was not appropriate to place the clean rags for catheter care on a surface without a barrier due to contamination. Contamination of the rags was a risk for urinary tract infections. She was familiar with Resident 16's care and aware the resident had a history of urinary tract infections. She indicated she had not had any recent in-services on urinary catheter care.			

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	During an interview on 3/9/23 at 3:33 p.m., the Clinical Supervisor indicated it was not appropriate infection prevention and control practice when a staff member placed the clean rags in preparation for urinary catheter care on a resident's end table or personal items without a barrier and then performed urinary catheter care with the contaminated rags. A current policy, dated 1/1/23, titled "Catheter Care," provided by Administrator 2 on 3/10/23 at 11:26 p.m., indicated the following: "GENERAL GUIDELINES...1. Gather all needed supplies. 2. Wash hands. 3. Using mild soap and water, clean the genital area....For a female, separate the labia and clean the area from front to back. 4. Clean the urethra (urinary opening) where the catheter enters the body. 5. Clean the catheter from the entrance of the body then down away from the body. Hold the catheter at the point closest to the body so that there is no tension on the catheter. 6. Rinse the area well and dry it gently...8. Wash hands...." A current policy, dated 1/1/23, titled "Proper Techniques for Urinary Catheter Maintenance," provided by Administrator 2 on 3/13/23 at 9:30 a.m., indicated the following: "Guidelines...1. Following aseptic insertion of urinary catheter, maintain a closed drainage system...2. Maintain unobstructed urine flow. a. Keep the catheter and collecting tube free from kinking. b. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. c. Empty the collecting bag regularly using a separate, clean collecting container for each patient; avoid splashing, and prevent contact of the drainage spigot with the nonsterile collecting container. 3. Use Standard Precautions, including the use of gloves and gown as appropriate, during any			

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	manipulation of the catheter or collecting system...." 3.1-41(a)(2)			
F 0740 SS=E Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on observation, interview, and record review, the facility failed prevent a lack of assessment/evaluation of residents prior to placement on a secured behavior unit; failed to ensure employees had specialized behavior management training, and failed to develop a specialized program for a secured "behavioral" unit for 6 of 6 residents reviewed for behavioral health services. (Residents. 38, 46, 27, 9, 39 & 29) Findings include: During an interview on 3/6/23 at 10:00 a.m., Administrator 1 indicated the facility did not have a secured memory care unit. The secured unit was instead a behavioral unit. During an interview on 3/6/23 at 11:21 a.m., the Human Resources Manager indicated the facility did not have a dementia unit director because the secured unit was a behavioral unit, not a dementia	F 0740	F740 It is the practice of the facility to provide each resident with the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.1. Corrective action accomplished for those residents found to be affected by the alleged deficient practice.a. The Clinical Director of the unit will initiate a new evaluation form that will be completed either pre-admission or upon arrival of a new resident to determine correct placement of the resident. The Clinical Director will consult with	03/31/2023

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	care unit. During an observation on 3/6/23 at 11:38 a.m., the 300 hall (Swan Hall) was observed to be a secured unit, with a key-pad style lock at both the entrances and exits. These key-pads required a code to be entered into the device in order for the doors to unlock for entrances and exits. Eleven (11) residents were observed moving about the unit, seated in the dining room, or in their room. During an interview on 3/8/23 at 11:20 a.m., Administrator 2 indicated the facility did not have a secured memory care unit. The secured unit was a behavioral unit. During an interview on 3/9/23 at 9:37 a.m., QMA 4, who was working on the secured unit, indicated the unit was a secured memory care unit and all the residents on the unit had dementia or a like disorder. She had been employed in the facility since January 2023 and had received the required dementia training. During an interview on 3/9/23 at 9:45 a.m., CNA 3, who was working on the secured unit, indicated the unit was a memory care unit for individuals with dementia or like disorders. She had been working at the facility since the end of January 2023. She believed all the residents who resided on the unit had dementia. During an interview on 3/10/23 at 9:30 a.m., Administrator 2 again indicated the secured unit was a behavioral unit not a dementia/memory care unit. The staff on the unit had experience working in psychiatric settings, which supported it being specialized for behavior management. The Psychiatric Nurse Practitioner had trained all the staff who worked on the unit. The employees had		our Psych NP prior to placement for approval and signature on the form.b. The Activities Department/Social Services will implement upon admission the appropriate care plan for the new resident to ensure an individualized/specialized programing will meet the resident's needs. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice.a. All residents that reside on the unit have the potential to be affected.b. All residents currently on the secure unit will be assessed by the Psych NP and the Clinical Director to ensure proper placement has occurred, families and appropriate POAs will be contacted via phone or in person care plan meeting to discuss the new assessment form and the results. A transfer/discharge notice will be given if they do not meet the requirements to stay on the unit.3. Measures and systemic changes put into place to ensure that the alleged deficient practice does not recur.a. All staff were in-serviced _____3/31/2023_____ in behavioral management programs for specialized plans, programs, and interventions. A third-party behavioral health training program called " Alliant Health Solution" was contacted for extra training for	

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	all received specialized dementia training, but all the residents on the secured unit had both dementia and behavioral concerns. During an interview on 3/10/23 at 9:38 a.m., CNA 3, who was working on the secured unit, indicated she did not have any experience in a psychiatric setting. She had not received any specialized behavior training specific to this secured unit. She did not remember having any training by the Psychiatric Nurse Practitioner and all behavioral training seemed to focus on dementia. During an interview on 3/10/23 at 9:41 a.m., QMA 4, who was working on the secured unit, indicated she did not have any psychiatric experience. Most of her behavioral training was related to dementia. She had not had any specialized behavioral training related to this unit. She had not had any training presented by the Psychiatric Nurse Practitioner since she began her employment in the facility in January 2023. Review of "In-Services Sign-In Sheets" related to behavioral training indicated only one training had been provided by the Psychiatric Nurse Practitioner during the past six- month period. The training was offered to 11 employees on 9/16/22. The "Bed Inventory", State Form 4332, completed by the facility on 3/6/23, indicated the the 300 hall secured unit (Swan Hall) had 11 rooms with the potential of housing 22 residents. Review of the "Resident Matrix" provided by the facility on 3/6/23 indicated Eleven (11) residents resided on the secured 300 Unit (Swan Hall) on 3/6/23.		all staff to be performed before next QAPI and ongoing training every quarter to ensure all staff is properly trained for behavior health/ specialized care for the residents that reside in the secure unit.b. We have appointed a new Clinical Director to oversee the secured unit. She will be monitoring that the appropriate placement is being followed and that activities are being performed based on their specialized/individual care plans. The new Director has received specialized training for behavioral management and will have on-going training yearly.4. The corrective action will be monitored to ensure the alleged deficient practice does not recure and quality assurance measures put into place are:a. We have appointed a new Clinical Director to oversee the secured unit. She will be monitoring that the appropriate placement is being followed and that activities are being performed based on their specialized/individual care plans. These audit sheets will be submitted to the Administrator for review. This will be completed weekly for the next 30 days, then bi-weekly for the next 30 days, then monthly for the next quarter. If there is a concern noted, it will be immediately corrected.b. The findings from these audits and any corrective	

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	An undated facility policy titled, "Criteria for Secure Unit", provided by Administrator 2 on 3/9/23 at 3:16 p.m., indicated the following: "...The facility will assess the potential risk as well as potential benefit to the resident. ... has been determined to be an elopement risk and/or benefit from specialized programming provided on the secured unity. ...BIMs [Brief Interview of Mental Status] of less than 13, Alzheimer's/Dementia diagnosis or other related disorders/diagnosis affecting the cognition or safety of the resident. ..." During an interview on 3/13/23 at 1:58 p.m., Administrator 2 indicated the facility did not have any written specialized programing information to provide related to the secured unit. In addition, the facility had never filed a "Alzheimer's/Dementia Special Care Unit" State Form 48896 because it was not a designated memory care unit. 1. During an interview on 3/7/23 at 10:16 a.m., Resident 38 indicated he had no idea why he resided in a secured unit. He did not have the code to exit the unit, and staff assisted him as he exited the unit to go outside and smoke. The residents on the unit were not conversational with him. The interview was the best conversation he had in a long time. Resident 38's clinical record was reviewed on 3/8/23 at 10:15 a.m. Current diagnoses included Schizoaffective disorder, generalized anxiety disorder, bipolar disorder, major depressive disorder, and catatonic schizophrenia. The resident did not have a diagnosis of dementia or a related disorder. The resident had a current 6/17/22, physician's order which indicated the resident should reside on a secured unit.		actions taken will be discussed during quarterly QA meetings and the current plan revised, as warranted.	

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	A 12/25/22, quarterly, Minimum Data Set (MDS) assessment indicated the resident was cognitively intact and displayed no maladaptive behaviors during the assessment period including wandering. A 6/20/22, care plan problem/need indicated the resident resided on a secured unit due to a diagnosis of catatonic schizophrenia. An approach to this problem/need was resident resides on a secured unit. The last four Nurse Practitioner's notes, dated 11/8/22, 11/18/22, 1/3/23, did not address any maladaptive behavioral concerns and focused primarily on pain management. A 1/21/23, "Wandering Risk Scale" was miscalculated to indicate the resident had "medical diagnosis of dementia/cognitive impairment; diagnosis impacting gait/mobility or strength." The form indicated the resident could follow directions, was ambulatory, and had not wandered in the last month. The comment section of the form it indicated the resident would ambulate with a destination in mind. The clinical record lacked the following: a. An assessment/evaluation regarding the resident's need for a secured behavioral unit prior to admission, upon admission or at any time since admission. b. An evaluation addressing why the resident could not reside in the facility on another unit with peers of his functioning level. c. Documentation regarding any exhibited behavioral symptoms being treated by residing on a secured unit. d. Documentation of any specialized treatment or			

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	programing being offered to the resident while residing on a secured unit. Resident 38 was observed on the unit, calm and without behaviors, during the follow dates and times: 3/6/23 at 3:04 p.m., being escorted by staff off of the unit for smoking, 3/8/23 at 9:59 a.m., waiting in the hallway by exit doors for smoke break, 3/9/23 at 941 a.m., resting in bed with the TV on. 3/9/23 at 11:53 a.m., the resident was awaiting lunch and involved in a casual conversation. The resident was never observed displaying maladaptive behaviors during the survey. 2. Resident 46's clinical record was reviewed on 3/13/23 at 11:45 a.m. Current diagnoses included mood disorder with depressed features, dementia, and anxiety. A current 10/12/22, physician's order indicated the resident should reside on a secured unit. A 1/16/23, quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired and exhibited physically aggressive behaviors, verbally aggressive behaviors, rejected care, and wandered 1 to 3 days of the assessment period. A current, 10/15/22, care plan problem/need indicated the resident was at risk for elopement. An approach to this problem/need was to reside on a secured unit. A current, 11/7/22, care plan problem/need indicated the resident wandered. An approach to this problem was to reside on a secured unit.			

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	The last five behavioral notes for 3/6/23, 1/25/23, 12/23/22, 12/22/22 and 11/18/22 were related to signs of agitation, resistance to care, and resistance to redirection. The clinical record lacked the following: a. An assessment/evaluation regarding the resident's need for a secured behavioral unit prior to admission, upon admission or any time thereafter, b. Documentation of how this resident, who has a diagnoses of dementia, was best served on a behavioral unit as opposed to a dementia unit, c. Documentation of any specialized treatment or programing being offered to the resident while residing on a secured unit. Resident 46 was observed on the unit, calm and without behaviors during the follow dates and times: 3/7/23 at 10:31 a.m., in the small lounge across from the nursing station, her head was bent far forward, 3/8/23 at 10:01 a.m., in the small lounge talking to the empty room, 3/9/23 at 9:48 a.m. and 11:42 a.m., in the small lounge in the recliner with her feet up, 3/10/23 at 9:44 a.m., in the small lounge in her wheelchair. During the survey process the only observed behaviors displayed by the resident were leaning far forward and talking to an empty room. 3. Resident 27's clinical record was reviewed on 3/8/23 at 10:10 a.m. Current diagnoses included traumatic brain injury and depression. A current 4/5/22, physician's order indicated the resident should reside on a secured unit.			

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	A 1/11/23 , significant change, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired and displayed no maladaptive behaviors during the assessment period. A current, 6/30/22 care plan problem/need indicated the resident was at list for elopement and wandering. An approach to this problem/need was reside on a secured unit. The last three Nurse Practitioner's Notes on 1/2/23, 1/5/23, and 12/15/22 focused on health related concerns. The notes did not address any behavioral concerns or the need for a behavioral unit. The clinical record lacked the following: a. An assessment/evaluation regarding the resident's need for a secured behavioral unit, prior to admission to the unit or any time thereafter, b. Documentation regarding an exhibited behavioral system being treated by residing on a secured unit, c. Documentation of any specialized treatment or programing being offered to the resident while residing on a secured unit. Resident 27 was observed on the unit, calm and without behaviors, during the follow dates and times: 3/6/23 at 3:06 p.m., in bed, 3/8/23 at 10:02 a.m., in bed, 3/9/23 at 9:49 a.m. and 11:43 a.m., in bed, 3/10/23 at 9:46 a.m., in bed. At no time during the survey process was the resident observed displaying any maladaptive behaviors.			

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	4. Resident 9's clinical record was reviewed on 3/13/23 at 10:35 a.m. Current diagnoses included dementia, anxiety, and depression. The resident had a current 1/6/23, physician's order which indicated the resident should reside on a secured unit. A 1/16/23, admission,Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired and wandered daily. A current, 1/9/23, care plan problem/need indicated the resident was at risk for elopement related to dementia. An approach to this problem/need was to reside on a secured unit. The clinical record lacked the following: a. An assessment/evaluation regarding the resident's need for a secured behavioral unit prior to admission, upon admission or anytime thereafter, b. Documentation of how this resident, who has a diagnoses of dementia, was best served on a behavioral unit as opposed to a dementia unit, c. Documentation of any specialized treatment or programing being offered to the resident while residing on a secured unit. Resident 9 was observed on the unit, calm and without behaviors during the follow dates and times: 3/8/22 at 10:00 a.m., in bed in her room, 3/9/23 at 9:37 a.m. and 11:41 a.m., in bed in her room, 3/10/23 at 9:44 a.m., seated in the small lounge across from the nursing station. The resident was never observed displaying any maladaptive behaviors during the survey process.			

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	5. Resident 39's clinical record was reviewed on 3/8/23 at 3:46 p.m. Current diagnoses included, Alzheimer's Disease, dementia with psychotic disturbance, and depression. A current 1/13/23, physician's order to reside on a secured unit. A 1/23/23, admission, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired, wandered daily, and required some level of staff assistance for all activities of daily living. The resident has a current, 1/13/23, care plan problem/need regarding long and short term memory issues due to dementia. An approach to this problem was to reside on the secured unit. The resident had a current, 1/13/23, care plan problem/need related to a risk of elopement. An approach to this problem was to reside on the secured unit. The clinical record lacked the following: a. An assessment/evaluation regarding the resident's need for a secured behavioral and/or dementia unit, prior to admission, upon admission, or anytime thereafter, b. Documentation regarding an exhibited behavioral system being treated by residing on a secured behavioral unit, c. Documentation regarding any specialized programing the resident was receiving while on the secured behavioral unit. Resident 39 was observed on the unit, calm and without behaviors during the follow dates and times: 3/7/23 at 10:35 a.m., in the recliner in the small lounge withe her feet up, appeared to be sleeping, 3/8/23 at 10:00 a.m., in the recliner in the small			

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	lounge with her feet up, 3/9/23 at 9:40 a.m., in bed moving about, 3/9/23 at 11:42 a.m., in the recliner in the small lounge with her feet up. At no time during the survey process was the resident observed displaying maladaptive behaviors. 6. Resident 29's clinical record was reviewed on 3/9/23 at 12:20 p.m. Current diagnoses included dementia, psychotic disorder with hallucinations, and Alzheimer's Disease. The resident had a current, 7/14/22, physician's order to reside in a secured unit. A 2/17/23,quarterly, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired, wandered daily, required some form of staff assistance for all activities of daily living and wandered daily during the assessment period. A current, 7/15/22, care plan problem/need indicated the resident was at risk for elopement. An approach to this problem was to reside in the secured unit. The resident had a current, 7/15/22, care plan problem/need regarding wandering due to Alzheimer's disease. An approach to this problem was to reside an a secured unit. The last three Nurse Practitioner's notes, from 1/12/23, 1/5/23, and 12/20/22, all related to a fall history. None of the notes addressed any specialized behavioral needs being addressed by the secured unit. The clinical record lacked the following:			

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	155400	A. BUILDING 00 B. WING	03/13/2023

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	a. An assessment/evaluation regarding the resident's need for a secured behavioral and/or dementia unit prior to admission, upon admission or any time thereafter, b. Documentation regarding an exhibited behavioral system being treated by residing on a secured unit, c. Documentation regarding any specialized programing the resident was receiving while on the secured behavioral unit. Resident 29 was observed on the unit, calm and without behaviors during the follow dates and times: 3/6/23 at 11:51 a.m., in the dining area awaiting lunch, 3/8/23 at 10:03 a.m., in bed, 3/9/23 at 9:36 a.m. and 11:43 a.m., in bed, 3/10/23 at 9:44 a.m., in the small lounge leaning far forward touching the floor and her lower leg. The only behavior observed during the survey process was leaning forward as mentioned above. 3.1-37 3.1-43			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or			

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	§483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review, the facility failed to provide a radiology test according to physician order to monitor medication effectiveness for 1 of 5 residents reviewed for unnecessary medications review. (Resident 17) Finding includes: Resident 17's clinical record was reviewed on 3/7/23 at 4:34 p.m. Diagnoses included, essential primary hypertension, deep vein thrombosis, and generalized anxiety disorder. Medications included Eliquis (anticoagulant) 5 mg twice daily. An order, revised on 6/1/22, indicated a venous doppler (radiology test) of the left lower extremity was ordered for a follow up to a previous deep vein thrombosis. If negative, then discontinue Eliquis. This order ended on 6/6/22. The clinical record lacked a repeat doppler of the left lower extremity three months after 6/7/22 (September 2022) to determine whether to discontinue the Eliquis (anticoagulant).	F 0757	F0757 It is the practice of this facility to provide each resident with a drug regimen that is free from unnecessary drugs utilization. 1. Corrective action accomplished for those residents found to be affected by the alleged deficient practice. a. A review of the plan of care and orders was completed on Resident # 17. The facility notified physician and received order for no further testing to be completed. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. All residents that reside on the unit have the potential to be affected. b IDT team to review 24 hour report each morning during morning meeting to ensure that all residents are not affected by an unnecessary drug regimen. c All resident's drug regimen	03/30/2023

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	Review of the Medication Administrator Record indicated Eliquis continued to be administered to the resident from Decameter 2022 through the survey period. A Nurse's Note, dated 6/3/22 at 9:43 a.m., indicated the doppler report was sent to the physician on 6/2/22. The provider planned to review the report and respond how to proceed in regard to the Eliquis administration. A Nurse's Note, dated 6/7/22 at 1:21 p.m., indicated an order was received to continue Eliquis for three months and repeat the left lower extremity doppler in three months. The clinical record lacked any documentation of communication with the physician to clarify if the doppler to the left lower extremity had been discontinued, and if the Eliquis could be discontinued. During an interview on 3/13/23 at 3:32 p.m., the Clinical Supervisor indicated the resident should have had a repeat venous doppler of the left lower extremity to determine if the resident should remain on Eliquis for a deep vein thrombosis, in the beginning of September 2022. The radiology test was not performed according to the physician order, and the resident remained on Eliquis to date. The physician orders should have been completed as ordered or documented otherwise if new orders were obtained. A current facility policy, dated 3/26/21, titled "Administration and Documentation of Medication," provided by Administrator 2 on 3/13/23 at 4:46 p.m., indicated the following: "...POLICY: It is the policy of this facility that every resident receives medications by a licensed nurse as prescribed by a licensed physician or		has been reviewed and follow ups have been placed on monthly desk calendars at each nursing station completed 3/30/23. d. The DON/ADON or designee will ensure follow up to all labs and xrays are completed and scheduled. Monitoring tool put into place for daily checks x 3 months and ongoing. 3. Measures and systemic changes put into place to ensure that the alleged deficient practice does not recur. a. IDT team to review 24 hour report each morning during morning meeting to ensure that all residents are not affected by an unnecessary drug regimen. b. The DON/ADON or designee will ensure follow up to all labs and xrays are completed and scheduled. Monitoring tool put into place for daily checks x 3 months, then weekly checks for 30 days, then every 2 weeks checks for 30 days, and then monthly for the next quarter. If a concern is noted, then immediate action is taken to correct. 4. The corrective action will be monitored to ensure the alleged deficient practice does not recure and quality assurance measures put into place are: a. The DON/ADON or designee will ensure follow up to all labs and xrays are completed and scheduled. Monitoring tool put into place for daily checks x 3	

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	other healthcare provider legally permitted to prescribe medications, safely, properly and in a timely manner and that medication shall be accurately and completely documented... GENERAL STANDARDS FOR MEDICATION ADMINISTRATION...7. If there is clinical data, such as vital signs required for medication administration, this must be obtained prior to administration... STANDARDS OF ORDER ENTRY 1. Residents with new/changed orders are to be noted on the 24 hour report... 3. Nurse entering order is responsible for setting up consults, appointments, lab work, x-rays, etc. as ordered prior to the end of shift... RESPONSIBILITY... 4. Nurses are responsible for consulting with pharmacist or physician as needed to resolve discrepancies or concerns regarding specific medications ordered...." 3.1-48(a)(4)		months, then weekly checks for 30 days, then every 2 weeks checks for 30 days, and then monthly for the next quarter. If a concern is noted, then immediate action is taken to correct. b. The findings from these audits and any corrective actions taken will be discussed during quarterly QA meetings and the current plan revised, as warranted.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

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	§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications and biologicals requiring refrigeration were maintained within the acceptable temperature range in 2 of 2 refrigerators reviewed for medication storage. (Medication refrigerators on the 200 and 300 hall) Findings include: 1. During an observation, on 3/9/23 at 10:01 a.m., the refrigerator in the 300 hall medication room contained medications/biologicals to include Trulicity injection pens (for diabetes), Levemir (insulin) injection pens, Risperdal Consta (anti-psychotic) 25 mg injection pens, bisacodyl (laxative) suppositories, and five doses of high dose quadrivalent flu vaccine. The refrigerator lacked a thermometer. On top of the refrigerator was a temperature log dated February 2023. Temperature entries were documented for the morning on February 1, 2, 3, 4, 5, and 6 and afternoon for February 6. The remaining days lacked entries in both the a.m. and p.m. During an interview, at the time of the observation, QMA 4 indicated the night shift was responsible for documenting the medication refrigerator temperature on the refrigerator log. She did not think she was supposed to document	F 0761	F761 It is the practice of this facility to ensure medications and biologicals requiring refrigeration were maintained within the acceptable temperature range. 1. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice. a. All meds affected in the refrigerator during survey were replaced at the facility expense. 2. To identify other residents who have the potential to be affected by the same alleged deficient practice. a. No residents were identified for the alleged deficient practice. b. All med room refrigerators were checked for proper temperatures, thermometer, and logs and no problems identified. 3. Measures and systemic changes put into place to ensure the at the alleged deficient practice does not recur. a. License Nurses and Q.M.A.'s was in-serviced ___3/29/23_____ for proper	03/30/2023

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	the temperature, as she had not been told to do so. During an interview, on 3/9/23 at 10:59 a.m., QMA 4 indicated there was no thermometer in the medication refrigerator. She was unable to locate the March 2023 medication refrigerator log. 2. During an observation, on 3/9/23 at 10:48 a.m., the refrigerator in the 200 Hall medication room contained Trulicity injection pens. The thermometer inside the refrigerator had a reading of 35 degrees Fahrenheit. No temperature log was present near or around the refrigerator. During an interview, on 3/9/23 at 11:41 a.m., LPN 10 indicated the refrigerators' temperatures were checked daily on night shift. The medication room was recently opened after remodeling and a refrigerator temperature log had not been started. During an interview, on 3/9/23 at 11:44 a.m., the Clinical Supervisor indicated the medication refrigerators should be checked twice daily. A facility document, titled "Refrigerator & Freezer Log," provided by QMA 4 on 3/9/23 at 11:03 a.m., indicated the following: " ...Refrigerator is to be at +36 degrees to 46 degrees F. A facility staff member must check and record date, time, and temperature two times each day, once during day shift and once during second shift ...." A current facility policy, dated 7/2012, provided by Administrator 2 on 3/10/23 at 2:29 p.m., and titled "Storage of Medications and Biologicals," indicated the following: "...Medications and biological are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier		temperatures, thermometer, and logs for medication refrigerators in med rooms. b. Temperatures will be recorded 2 times daily on log to maintain appropriate temperatures. If discrepancy is noted, then immediate action will be taken to correct. 4. The corrective action will be monitored to ensure the alleged deficient practice does not recur and quality assurance measures put into place are: a. The DON and/or Designee will monitor temperature log at a minimum of 3 times weekly at random for 30 days, then 2 times weekly at random for 30 days, then 1 time weekly at random for 30 days. If any discrepancies are noted, then immediate action will be taken to correct. b. The findings from these audits and any corrective actions taken will be discussed during quarterly QA meetings and the current plan revised, as warranted.	

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	...Medications requiring 'refrigeration' or 'temperatures between 2 degrees Celsius (36 degrees Fahrenheit) and 8 degrees Celsius (46 degrees Fahrenheit) are kept in a refrigerator with a thermometer to allow temperature monitoring ...." Review of the Trulicity website, accessed at www.trulicity.com on 3/13/23 at 4:12 p.m., indicated the Trulicity pen is to be stored in the refrigerator between 36- and 46-degrees Fahrenheit. If the pen is frozen, it is to be thrown away. According to the CDC website, accessed on 3/13/23 at 4:17 p.m. at www.cdc.gov, refrigerator temperatures containing vaccines are to be checked and recorded at least twice a day. 3.1-25(m)			